# Blue Cross® Gold, a Multi-State Plan Benefits Certificate

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

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

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

> Your certificate, your signed application and your BCBSM identification card are your **contract** with us.
>
> You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

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

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

# About Your Certificate

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

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

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

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# Section 1: Information About Your Contract

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

- **ELIGIBILITY**
  - Who is Eligible for Individual Coverage
  - Who is Eligible to Receive Benefits
  - End Stage Renal Disease (ESRD)
  - When You Can Enroll
  - Contract Dates
- **BILLING**
  - Information About Your Bill
  - How Rates Are Classified
- **TERMINATION**
  - How to Terminate Coverage
  - Termination
  - Rescission
- **CHANGING YOUR COVERAGE**

# ELIGIBILITY

## *Who is Eligible for Individual Coverage*

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

- You are a resident of Michigan and a U.S. citizen or legally present and live in the state at least 180 days a year
- You, your spouse or dependents do not have or are not eligible for Medicare

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

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

If you are eligible for Medicare and Medicare covers a service, this same service is not payable under this contract.

- If you are a minor child, you are eligible for a child-only certificate.

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

## *Who is Eligible to Receive Benefits*

You, your spouse and your children listed on your contract are eligible. You will need to complete an application for coverage.

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

NOTE

If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact in your application, your coverage may be rescinded. See "Rescission" on Page 8.

NOTE

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

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

- Birth
- Marriage
- Legal adoption
- Legal guardianship.

Children must be Michigan residents, unless they live somewhere else temporarily (as in the case of college students).

- After the end of the year in which your child turns 26, the child must have his/her own coverage.

NOTE

Your child's spouse and your grandchildren are not eligible for coverage under this certificate.

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

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

NOTE

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

If there is a change in your family, such as birth, adoption, marriage, divorce, or death of a member, please see "Changing Your Coverage" on page 8.

## *End Stage Renal Disease (ESRD)*

Members with ESRD have the option to either:

- Remain covered under this certificate
- Enroll in Medicare and remain covered under this certificate, or
- Transition fully to Medicare coverage.
- If you elect to keep your coverage under this certificate without enrolling in Medicare:
- You will no longer be eligible for a federal premium tax credit, and
- You may incur a late enrollment penalty if you later elect to enroll in Medicare.

For members electing to enroll in Medicare and remain covered under this certificate, we coordinate with Medicare to pay for ESRD treatment. This includes hemodialysis and peritoneal dialysis.

Dialysis services must be provided in:

- An in-network or participating hospital
- An in-network or participating freestanding ESRD facility or
- In the home.

**When Medicare Coverage Begins**

If you have ESRD, your Medicare starts on the first day of the fourth month of dialysis.

Dialysis begins February 12. Medicare coverage begins May 1.

The time before Medicare coverage begins is the “Medicare waiting period.” It lasts for three months.

There is no waiting period if you begin self-dialysis training within three months of when your dialysis starts. If so, Medicare coverage begins the first day of the month you begin dialysis.

There is no waiting period if you go in the hospital for a kidney transplant or services you need before the transplant. (The hospital must be approved by Medicare.) Medicare coverage begins the first day of the month you go in. You must receive your transplant within three months of going in the hospital.

Sometimes transplants are delayed after going in the hospital. If it is delayed more than two months after you go in the hospital, Medicare coverage begins two months before the month of your transplant.

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

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

## *When You Can Enroll*

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

## *Contract Dates*

When Your Benefits Begin

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

# BILLING

## *Information About Your Bill*

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

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

- You are responsible only for your portion of the premium, not any applicable amount covered by the subsidy.

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

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

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

- You are responsible for the entire premium amount

- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.

- The three-month grace period does not apply if you do not receive a premium tax credit. If we do not receive your premium by the due date, we will allow you a grace period of 31 days, during which we will send you a final bill. Your coverage will not continue during the 31-day grace period. If we do not receive your premium payment during the grace period, your coverage will be terminated or cancelled as of the last day of paid coverage.

We will accept payment of your health insurance premium only from you, your spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay your premium on your behalf.

## *How Rates Are Classified*

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

Your rate will be:

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

  PLUS

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

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

# TERMINATION

## *How to Terminate Your Coverage*

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

However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition “Services Before Coverage Begins or After Coverage Ends.”

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

If you bought coverage under this certificate on the Marketplace, you may terminate it only if you contact the Marketplace with proper notice. The effective date of your request will be one of the dates described in Section 6, under “Termination of Coverage”.

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

## *Termination*

We will terminate your coverage if:

- You no longer qualify for coverage under this certificate
- You do not pay your bill on time, subject to the applicable grace period (see page 145)
- You are serving a criminal sentence for defrauding BCBSM
- You cannot provide proof you live in Michigan at least 180 days a year
- We no longer offer this coverage
- You **misuse** your coverage

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

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

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process.
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally

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

## *Rescission*

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

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

We may rescind your coverage back to the effective date of your contract. If we do, we will provide you with 30 days’ notice. You will have to repay BCBSM for its payment for any services you received during this period.

## CHANGING YOUR COVERAGE

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

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

- A birth
- Adoption
- Marriage
- Divorce or
- Death of a member.

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

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

If a member on your contract dies, please notify us, and your rate will be adjusted as of the date of death. However, you may not change your coverage until the next open enrollment period, except as established by federal law.

If the subscriber dies, the contract must be rewritten to reflect a new subscriber and the rate will be adjusted.

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

# Section 2: What You Must Pay

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

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

| Choosing Your Provider | | |
|---|---|---|
| If you receive services from an **In-Network Provider** | If you receive services from an **Out-of-Network Provider** | |
| | **Participating Provider*** This out-of-network provider participates with BCBSM. | **Nonparticipating Provider*** This out-of-network provider chooses not to participate with BCBSM. |
| Provider accepts the BCBSM approved amount as payment in full.<br><br>You will pay the least out-of-pocket costs:<br>• Lower deductible<br>• Lower copayment and coinsurance amounts<br>• No deductible, copayment or coinsurance for certain preventive care benefits<br><br>No claim forms to file | Provider accepts the BCBSM approved amount as payment in full.<br><br>You will pay more out-of-pocket costs than what you pay if you see an in-network provider (unless you are referred by a PPO in-network provider):<br>• Higher deductible, unless noted<br>• Increased out-of-network copayment and coinsurance amounts<br>• No deductible, copayment or coinsurance for certain preventive care benefits<br><br>No claim forms to file | Provider does not accept the BCBSM approved amount as payment in full**<br><br>You will pay the highest out-of-pocket costs (unless you are referred by a PPO in-network provider):<br>• Higher deductible<br>• You pay all charges that exceed the amount we pay for a service.<br>• Increased copayment and coinsurance amounts unless noted (e.g., see emergency services on Page 116)<br>• Higher out of pocket maximum<br><br>You must file claim forms |
| ***Important:** Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers cannot bill you for more than our payment plus what you pay in cost-sharing. Nonparticipating providers can bill you for the amount that is more than what we pay.<br><br>** Some nonparticipating providers participate on a per claim basis. That is, they accept our payment plus what you pay in cost-sharing on a one-time basis. | | |

Section 4 on page 130 explains more about providers such as physicians, hospitals and others. That section also explains how we pay providers.

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

**The basic deductibles, copayments and coinsurances you must pay each calendar year are illustrated in the chart below and explained in more detail in the pages that follow. These are standard amounts associated with this certificate. The amounts for which you are responsible may differ depending on what riders your particular plan has. Deductible, copayment AND coinsurance apply to some services.**

| | In-network | Out-of-network |
|---|---|---|
| **Deductibles*** <br><br> *See NOTE on page 12 about deductible amounts | $150 for one member <br> $300 for the family (when two or more members are covered under your contract) | $300 for one member <br> $600 for the family (when two or more members are covered under your contract) |
| **Copayments** | $30 copay per primary care office visit, office consultation and pre-surgical consultation in a primary care office, home visit and outpatient visit <br> $50 copay per specialist office visit, office consultation and pre-surgical consultation in a specialist office, home visit and outpatient visit <br> $75 copay per urgent care visit in physician office, freestanding urgent care center or outpatient urgent care center in a hospital <br> $200 copay per imaging service (CT scans, MRI, PET Scans, etc.) <br> $250 copay per emergency room visit (waived if admitted) <br> $500 copay per inpatient admission to an acute care hospital, long term acute care hospital, skilled nursing facility, psychiatric facility, psychiatric residential treatment facility or residential substance abuse facility <br><br> *See Section 3 for Prescription Drug Copayments* | |
| **Coinsurance** | 20% of the approved amount for most covered services <br> 50% of the approved amount for bariatric surgery, temporomandibular surgery, infertility testing and treatment, prosthetics and orthotics, and durable medical equipment (except diabetes supplies) after in-network deductible has been met | 40% of the approved amount for most covered services <br> 70% of the approved amount for bariatric surgery, temporomandibular surgery, infertility testing and treatment, prosthetics and orthotics, and durable medical equipment (except diabetes supplies) after out-of-network deductible has been met |
| **Annual out-of-pocket maximums** | $5,100 for one member <br> $10,200 for the family (when two or more members are covered under your contract) | $10,200 for one member <br> $20,400 for the family (when two or more members are covered under your contract) |
| **Lifetime dollar maximum** | None | |

For additional benefit-specific cost-sharing requirements, please continue to read this section.

## *Deductible Requirements*

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

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

**If the contract is a family contract, and one member on the contract meets the individual deductible, BCBSM will begin paying covered benefits for that member only. The remainder of the family deductible must be met by one or more family members before BCBSM will begin paying covered benefits for the rest of the members on the family contract.**

- Deductibles paid in one calendar year are not applied to the deductible you must pay the following year.
- In-network and out-of-network deductibles may not be combined to satisfy this certificate's in-network or out-of-network deductible requirements.
- Payments for the following will not be applied to your deductible:
  - Noncovered services or charges that exceed our approved amount or
  - Copayments and coinsurances

Benefits for the following are **not** subject to deductible:

- Preventive benefits,
- Provider-delivered care management services performed by designated in-network providers as identified by BCBSM rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out of state. Out-of-network services are not covered.

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

**In-Network Deductible**

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

- $150 for one member
- $300 for the family (when two or more members are covered under your contract)

**If the contract is a family contract, and one member on the contract meets the individual deductible, BCBSM will begin paying covered benefits for that member only. The remainder of the family deductible must be met by one or more family members before BCBSM will begin paying covered benefits for the rest of the members on the family contract.**

**Out-of-network Deductible**

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

- $300 for one member
- $600 for the family (when two or more members are covered under your contract)

**If the contract is a family contract, and one member on the contract meets the individual deductible, BCBSM will begin paying covered benefits for that member only. The remainder of the family deductible must be met by one or more family members before BCBSM will begin paying covered benefits for the rest of the members on the family contract.**

You do not have to pay an out-of-network deductible when:

- An in-network provider refers you to an out-of-network provider (Note: Preventive services are covered in-network only)

  NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network deductible requirements

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO network
- You receive services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

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

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM.

You may contact BCBSM for more information about these services.

NOTE: If the above applies and you do not have to pay the out-of-network deductible, you will still need to pay the in-network deductible (if any).

## *Coinsurance Requirements*

*See "Prescription Drugs" in Section 3 beginning on Page 72 for what you must pay for prescribed drugs obtained from a pharmacy.*

Unless we state otherwise, after your in-network or out-of-network deductible has been met, you must pay a coinsurance for most covered services.

**In-Network Coinsurance**

Your coinsurance for most services provided by in-network providers is:

- **20 percent** after the in-network deductible is paid.

**EXCEPTIONS:** The coinsurance for the following services is **50 percent** after the in-network deductible is paid:

- Bariatric surgery
- Temporomandibular surgery
- Infertility testing and treatment
- Prosthetics and orthotics
- Durable medical equipment (except diabetes supplies)

The following services are **not** subject to coinsurance:

- Preventive services
- Hospice care
- Primary care or specialist office visits or consultations
- Provider-delivered care management services (see the definition on page 176). These services must be obtained from providers approved by BCBSM, if they are in Michigan. If outside of Michigan, the providers must be approved by the local Blue Cross Blue Shield plan in that state. Out-of-network services are not covered.

**Out-of-Network Coinsurance**

Your coinsurance for most services provided by out-of-network providers is:

- **40 percent** after the out-of-network deductible is paid.

You will **not** need to pay the 40 percent coinsurance for covered out-of-network services when an in-network provider refers you to an out-of-network provider. However, those services **will** be subject to in-network coinsurance requirements.

NOTE

You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network coinsurance requirements.

**EXCEPTIONS:** The coinsurance for the following services is **70 percent** after the out-of-network deductible is paid:

- Bariatric surgery
- Temporomandibular surgery
- Infertility testing and treatment
- Prosthetics and orthotics
- Durable medical equipment (except diabetes supplies)
-

## *Copayment Requirements*

*See "Prescription Drugs" in Section 3 beginning on Page 72 for what you must pay for prescribed drugs obtained from a pharmacy.*

After your in-network and out-of-network deductibles and coinsurance, then you are required to pay copayments for select covered services, listed below:

- $30 copayment in-network (out-of-network office visits are not payable) for:
  - A primary care physician office, home or outpatient visit
  - An office consultation
  - A pre-surgical consultation

NOTE

Coinsurances do not apply to primary care office visits or consultations

Diagnostic and laboratory services performed in the physician's office are subject to deductible and coinsurance requirements.

- $50 copayment in-network (out-of-network office visits are not payable) for:

  - A specialist's office, home or outpatient visit
  - An office consultation with a specialist
  - A pre-surgical consultation with a specialist

Coinsurances do not apply to specialist office visits or consultations.

Diagnostic and laboratory services performed in the physician's office are subject to deductible and coinsurance requirements.

You do not pay an in-network copayment for certain provider-delivered care management services (see the definition on page 176). These services must be obtained from providers approved by BCBSM, if they are in Michigan. If outside of Michigan, the providers must be approved by the local Blue Cross Blue Shield plan in that state. Out-of-network services are not covered.

- $75 copayment per urgent care visit in:

  - A physician's office (covered in-network only)
  - A freestanding urgent care center (in-network or out-of-network) or
  - An outpatient urgent care center in a hospital (in-network or out-of-network)

Diagnostic and laboratory services provided in any urgent care location (in-network or out-of-network) are subject to your in-network or out-of-network deductible and coinsurance requirements.

- $200 copayment per imaging service (CT scans, MRI, PET Scans, etc.) (in-network or out-of-network)

- $250 copayment per visit for facility services in a hospital emergency room (in-network or out-of-network). The $250 copayment is not applied if the patient is admitted.

- $500 copayment per inpatient admission (in-network or out-of-network) to:

  - An acute care hospital
  - A long term acute care hospital
  - A skilled nursing facility
  - A psychiatric facility, psychiatric residential treatment facility or residential substance abuse facility.

For inpatient maternity admissions to a hospital or approved birthing center, the $500 inpatient copayment will be applied only for the mother, not for the newborn.

## *Out-of-Pocket Maximums*

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

**Out-of-pocket Maximums for In-Network Services**

All in-network deductibles, coinsurance and copayments for covered medical and prescription drug services combine to meet the in-network out-of-pocket maximum. Once your out-of-pocket maximum is met, no more deductible, coinsurance or copayments will be required for the remainder of the calendar year.

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

- $5,100 for one member
- $10,200 for the family (when two or more members are covered under your contract)

**If the contract is a family contract, and one member on the contract meets the individual out-of- pocket maximum, BCBSM will begin paying 100% of the approved amount for covered benefits for that member only. The remainder of the family out-of-pocket maximum must be met by one or more family members before BCBSM will begin paying 100% of the approved amount for covered benefits for the rest of the members on the family contract.**

**Out-of-pocket Maximums for Out-of-Network Services**

All out-of-network deductibles, coinsurance and copayments for covered medical services combine to meet the out-of-network out-of-pocket maximum. Once your out-of-pocket maximum is met, no more deductible, coinsurance or copayments will be required for the remainder of the calendar year.

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

- $10,200 for one member
- $20,400 for the family (when two or more members are covered under your contract)

**If the contract is a family contract, and one member on the contract meets the individual out-of- pocket maximum, BCBSM will begin paying 100% of the approved amount for covered benefits for that member only. The remainder of the family out-of-pocket maximum must be met by one or more family members before BCBSM will begin paying 100% of the approved amount for covered benefits for the rest of the members on the family contract.**

# Section 3: What BCBSM Pays For

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

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

  You should call BCBSM customer service for a list of services requiring preauthorization before you use services. Payment will be denied if preauthorization was not approved before you used these services.

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

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

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

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

You must pay copayments, coinsurance and/or a deductible for many of the benefits listed. For what you may be required to pay, see Section 2: "What You Must Pay."

**We pay for services received from:**

- Hospitals and other facilities

  We pay for covered services you receive in hospitals and other BCBSM-approved facilities. Your attending physician must prescribe the services before we will cover them. Covered services may be received while you are in a hospital inpatient or outpatient department. You also may receive outpatient services in facilities other than a hospital.

  NOTE Emergency services do not need to be preapproved by your attending physician.

- Physicians and other professional providers

  Covered services must be provided by persons who are legally qualified or licensed to provide them.

  NOTE Some physicians and other providers do not participate with BCBSM. They do not bill BCBSM, but bill you instead. If you receive services from such a provider while you are in a hospital, the provider may bill you more than what we pay. We will reimburse you our approved amount but you must pay the difference. See "Nonparticipating Physicians and Other Providers" in Section 4.

## *Allergy Testing and Therapy*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For other diagnostic services, see Page 33.

Locations: We pay for allergy testing and allergy therapy in:

- A hospital (inpatient or outpatient)
- An ambulatory surgery facility
- A physician's office (in-network only).

**We pay for these services when performed by or supervised by a physician:**

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

**We do not pay for:**

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

## *Ambulance Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For emergency treatment services, see Page 39.

**We pay for:**

Ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition. Services must be rendered by an ambulance that participates under BCBSM's Traditional program.

In any case, the following conditions must be met:

- The service must be medically necessary; any other means of transport would endanger the patient's health.

- We only pay for the transportation of the patient. We do not pay for other services that might be billed with it.

- We only pay to transport the patient to a hospital or to transfer the patient to another treatment location. Other treatment locations may be:

  - Another hospital
  - A skilled nursing facility
  - A medical clinic
  - A dialysis center
  - The patient's home

  NOTE If the patient is being transferred, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and that is part of a licensed ambulance operation.

We pay for ground and air ambulance services when:

- The ambulance arrives at the scene but the patient is stabilized so transport is not needed or is refused.

- The ambulance arrives at the scene but the patient has expired.

**Ambualance Services** (continued)

**We pay for** (continued)

Air Ambulance

When transport by an air ambulance is required, the following conditions must be met:

- The use of an air ambulance is medically necessary and ordered by the attending physician.
- No other means of transport is available, or the patient's condition requires transport by air rather than ground ambulance.
- The patient is transported to the nearest facility capable of treating the patient's condition and
- The provider is licensed as an air ambulance service and is not a commercial airline.

**We do not pay for:**

Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.

## *Anesthesiology Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for anesthesiology services, subject to the conditions listed below, in a:

- Hospital (inpatient or outpatient)
- Participating ambulatory surgery facility
- Physician's office

**We pay for:**

- Anesthesiology during surgery

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

  - A physician other than the operating physician

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

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

    - Inpatient hospital setting
    - Outpatient hospital setting
    - Participating ambulatory surgery facility
    - Physician's office

    CRNA services must be:

    – Directly supervised by the physician performing the surgery or procedure or
    – Under the indirect supervision of anesthesiology services

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

- Anesthesia during infusion therapy

  – We pay for local anesthesia only when needed as part of infusion therapy done in a physician's office.

- Other Services

  – Anesthesia services may also be covered as part of electroshock therapy (see Page 52) and for covered dental services (see Page 30).

## *Autism Disorders*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of autism spectrum disorders, including:

- Autistic Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified, as described below.

Covered Services

We pay for diagnostic services provided by:

- A licensed physician
- A licensed psychologist

We pay for:

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

NOTE For BCBSM to pay for the above services, a BCBSM-approved autism evaluation center must confirm that the member has one of the covered disorders.

**Treatment** includes the following evidence-based care if prescribed or ordered by a licensed physician or licensed psychologist for a member who has been diagnosed with one of the covered autism spectrum disorders:

- **Applied Behavioral Analysis (ABA) treatment**
  - Treatment must be given or supervised by one of the following:
    - A board certified behavior analyst

NOTE We will pay for ABA services given by board certified behavior analysts. Any other treatment will not be paid including, but not limited to, treatment of traumatic brain injuries.

    - A licensed psychologist

NOTE The psychologist must have adequate formal university training and supervised experience in ABA.

**Autism Disorders** (continued)

- **Applied Behavioral Analysis (ABA) treatment** is covered subject to the following requirements:

  - **Treatment plan** – A BCBSM-approved autism evaluation center that evaluates the member will recommend a treatment plan. The plan must include ABA treatment. If BCBSM requests treatment review, BCBSM will pay for it.

  - **Prior authorization** – ABA treatment must be approved by BCBSM before treatment is given. If not, you will have to pay for it. Other autism services do not have to be approved beforehand.

  - **Behavioral health treatment (BHT)** – Evidence-based counseling is part of BHT. A licensed psychologist must perform or supervise it. The psychologist must have adequate formal university training and supervised experience in BHT.

  - **Psychiatric care** – It includes a psychiatrist's direct or consulting services. The psychiatrist must be licensed in the state where he/she practices.

  - **Psychological care –** A psychologist's direct or consulting services. The psychologist must be licensed in the state where he/she practices.

    NOTE

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

  - **Therapeutic care –** Evidence-based services from licensed providers. It includes:

    – Physical therapy
    – Occupational therapy
    – Speech and language pathology
    – Services from a social worker
    – Nutritional therapy from a physician
    – Genetic testing, as recommended in the treatment plan

Coverage Requirements

All autism services and treatment must be:

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

NOTE

Autism treatment or services deemed experimental or investigational by BCBSM, such as ABA treatment, are covered only if:

– Pre-approved by BCBSM
– Included in the treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition

**Autism Disorders** (continued)

**Limitations and Exclusions**

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

- We pay for ABA treatment for members through the age of 18. This limitation does not apply to:
  - Other mental health services to treat or diagnose autism
  - Medical services, such as physical therapy, genetic testing or nutritional therapy to treat or diagnose autism
- All covered autism benefits are subject to the cost-sharing requirements in this certificate. This includes, but is not limited to:
  - Medical-surgical services
  - Behavioral health treatment
- We do not pay for treatments that are not covered benefits. Examples are:
  - Sensory integration therapy
  - Chelation therapy
- We do not pay for treatment of conditions such as:
  - Rett's Disorder
  - Childhood Disintegrative Disorder
- When a member receives pre-approved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in your certificate such as the exclusion of:
  - Experimental treatment
  - Treatment of chronic, developmental or congenital conditions
  - Treatment of learning disabilities or inherited speech abnormalities
  - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.
- We only pay for autism services performed in Michigan from participating or nonparticipating providers who are registered with BCBSM.
- We only pay for autism services performed outside Michigan from providers who participate with their local Blue Cross/Blue Shield plan.

## *Cardiac and Pulmonary Rehabilitation*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

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

- A participating hospital (inpatient or outpatient)
- An in-network physician's office
- A clinic or a physician-directed clinic (one in which a physician is on-site)

**We pay for:**

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

**We do not pay for:**

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

## *Chemotherapy*

For high dose chemotherapy used in bone marrow transplants, see Pages 118 – 120.

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

**We pay for** chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the prior authorization requirement for specialty pharmaceuticals described on Page 88.

To be payable, the drugs must be:

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

NOTE

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

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

**We also pay for:**

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

NOTE

Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on Pages 37 to 38.

**We pay for the outpatient treatment of breast cancer.**

## *Chiropractic Services and Osteopathic Manipulative Therapy*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for the following in a physician's office subject to the conditions described below:

- Chiropractic services
- Osteopathic manipulative therapy

When received with physical therapy, see Page 69.

**We pay for:**

- Osteopathic manipulation therapy (OMT) on any location of the body
- Chiropractic spinal manipulation (CSM) to treat misaligned or displaced vertebrae of the spine and chiropractic manipulations (CM) to treat other areas of the body allowed by BCBSM
- Chiropractic office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received chiropractic services within the past 36 months.
  - For established patients: We pay for medical office visits. An established patient is one who has received chiropractic services within the past 36 months.
- Physical therapy that is part of a physical therapy treatment plan prepared by your chiropractor. The plan must be signed by your M.D. or D.O. **before** you receive physical therapy services for those services to be covered. If a treatment plan is not signed by your M.D. or D.O. before services are rendered, the services will not be covered and you may have to pay for them.
  - A signed treatment plan is not required for the first physical therapy service your chiropractor performs on you.

NOTE

Visits for physical therapy are applied toward your 30 visit benefit limit for physical and occupational therapy services.

NOTE

The following therapies are limited to a **combined** maximum of 30 visits (in-network and out-of-network providers combined) per member per calendar year:

- Osteopathic manipulation therapy
- All chiropractic manipulations
- Physical therapy including mechanical traction
- Occupational therapy

NOTE

Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if mechanical traction and spinal manipulation are provided on the same day, the services are counted as one visit.

- Mechanical traction once per day when it is given with CM. These visits are applied toward your 30 visit limit for physical and occupational therapy services.
- X-rays when medically necessary

## *Chronic Disease Management*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

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

- A hospital (inpatient or outpatient)
- A physician office
- An approved facility
- A home.

**We pay for:**

Chronic disease management services provided by:

- Physicians
- Certified nurse practitioners
- Certified licensed social workers
- Psychologists
- Physical therapists.

## *Clinical Trials (Routine Patient Costs)*

See Section 2 beginning on Page 10 for what you may be required to pay for these services.

For oncology clinical trial services, see Page 60.

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

NOTE Cancer drugs required by Michigan law are covered.

**We pay for:**

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

NOTE You can find the following definitions in Section 7:

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

**We do not pay for**:

- The experimental or investigational item, device or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

## *Dental Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For dental surgery, see Page 111.

Locations: We pay for emergency dental care given in:

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

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

**We pay for:**

- Emergency Dental Care

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

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

- Dental Services in a Hospital

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

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

    Examples of such medical conditions are:

    - Bleeding or clotting abnormalities
    - Unstable angina
    - Severe respiratory disease
    - Known reaction to analgesics, anesthetics, etc.

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

    Procedures that are payable in the circumstances explained above include:

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

**We par for** (continued)

**Dental Services in a Hospital** (continued)

- Other Dental Services
  - Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:
    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
    - Diagnostic X-rays
    - Physical therapy (see Page 69 for physical therapy services)
    - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

**We do not pay for:**

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

## *Diagnostic Services*

For allergy testing services, see Page 19.
For diagnostic radiology services, see Page 99.
For mental health diagnostic services, such as psychological testing, see Page 52.

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for diagnostic services subject to the conditions described below, in:

- A hospital (inpatient or outpatient)
- A participating ambulatory surgery facility
- A participating skilled nursing facility
- A physician's office.

Diagnostic and laboratory services performed in the physician's office are subject to deductible and coinsurance requirements.

**We pay for:**

Diagnostic Testing

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

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

  An independent physical therapist may give these tests. The test must be prescribed by a physician. The therapist must be certified by the American Board of Physical Therapy Specialties.

**Diagnostic Services** (continued)

Diagnostic Laboratory and Pathology Services

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

- In a hospital (under the direction of a pathologist employed by the hospital) or
- In a physician's office for standard office laboratory tests approved by BCBSM and in connection with medical care. (We do not pay for nonstandard tests performed in a physician's office). Tests must be provided by the patient's attending physician or by another physician, if prescribed by the attending physician, or
- By a laboratory when prescribed by a physician

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

- By a participating substance abuse facility in connection with treatment of substance abuse, or
- By your in-network physician, or
- By another physician, if your in-network physician refers you to one, or
- By an in-network lab at your in-network physician's direction.
  - We pay for standard office lab tests in your in-network physician's office. Other lab tests must be sent to an in-network laboratory.
  - You will need to pay the out-of-network cost-share if tests are done by an out-of-network lab or in an out-of-network hospital.

## *Dialysis Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

**Important:** **BCBSM shares the cost of treating End Stage Renal Disease (ESRD) with Medicare. It is important that you apply for Medicare coverage if you have ESRD. This is done through the Social Security Administration.** (Please see Pages 4 through 7 for a detailed explanation of ESRD.)

Locations: We pay for dialysis services subject to the conditions below, in:

- An in-network or participating hospital (inpatient or outpatient)
- An in-network or participating freestanding ESRD facility
- A home (when provided by a program participating with BCBSM to provide such services)

**We pay for:**

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

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

  End Stage Renal Disease

  We pay for treatment of ESRD until the patient becomes eligible for Medicare. This period is a maximum of three months from when you apply for Medicare. Afterward, BCBSM shares the cost of treatment with Medicare. If you have ESRD, you should apply for Medicare coverage. This is done through the Social Security Administration. See Pages 4 through 7 for details about ESRD.

**Services Provided in a Freestanding ESRD Facility**

**We pay for:**

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

**Services Provided in a Freestanding ESRD Facility** (continued)

**We do not pay for:**

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

**Services Provided in the Home**

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

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

**We pay for:**

- Home hemodialysis
  - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
  - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines
- Placement and maintenance of a dialysis machine in the patient's home
- Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
- Laboratory tests related to the dialysis
- Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
- Removal of the equipment after it is no longer needed

**We do not pay for:**

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

## *Durable Medical Equipment*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for durable medical equipment in the following locations subject to the conditions described below:

- In-network or participating hospital (inpatient or outpatient)
- Participating skilled nursing facility (see Page 101)
- In the home or during home infusion therapy (see Page 47)
- Hospice care (see Page 41)

**We pay for:**

- Use of durable medical equipment while you are in the hospital.
- The rental or purchase of durable medical equipment, if your physician prescribes it. (A certified nurse practitioner may prescribe it too.) You may obtain it from:
  - A hospital (when you are discharged)
  - A DME supplier approved by BCBSM

NOTE

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

**DME items must meet the following guidelines:**

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

NOTE

If the equipment is:

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

**Durable Medical Equipment** (continued)

Continuous Positive Airway Pressure (CPAP)
When prescribed by a physician, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.
  - We will pay for the purchase of any related supplies and accessories.
- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier must document your compliance.
- If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment.
  - If you fail to comply with treatment requirements, we will also no longer cover the purchase of supplies and accessories.

**Enteral and Supplemental Feeding Supplies**

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

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

**We do not pay for**:

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

## *Emergency Treatment*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For urgent care services, please see Page 124.

Locations: We pay for services to treat medical emergencies and accidental injuries subject to the conditions described below, in:

- A hospital
- A participating ambulatory surgery facility (a participating ASF is considered an in-network provider)
- An urgent care center
- A physician's office.

**We pay for:**

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

For a definition of "emergency services," see Section 7.

## *Home Health Care Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for care and services provided in the patient's home as an alternative to long-term hospital care. Home health care must be:

- Prescribed by the attending physician
- Provided and billed by a **participating** home health care agency
- Medically necessary (as defined in Section 7)

The following criteria for home health care must be met:

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

**We pay for:**

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

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, occupational therapy and speech and language pathology services as described on Pages 56, 69 and 103 are payable when provided for rehabilitation and are subject to the 30-visit limit.
- Part-time health aide services, including preparing meals, laundering, bathing and feeding **if**:
  - The patient is receiving skilled nursing care or physical or speech therapy
  - The patient's family cannot provide the services **and** the home health care agency has identified a need for these services for the patient to participate in the program
  - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

**Home Health Care Services** (continued)

**We pay for:** (continued)

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

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the patient is participating in the program
- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment plan ordered by the physician

**We do not pay for:**

- General housekeeping services
- Transportation to and from a hospital or other facility
- Private duty nursing
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
- Durable medical equipment (when billed by the home health care agency unless the agency is an approved DME provider)
- Physician services (when billed by the home health care agency)
- Custodial or nonskilled care
- Services performed by a nonparticipating home health care provider

## *Hospice Care Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for hospice care services subject to the conditions described below, in:

- A participating hospice facility
- A participating hospital
- A participating skilled nursing facility
- The patient's home (see Page 101 for when services may be payable in a nursing home).

**We pay for services to care for the terminally ill. Services must be provided through a participating hospice program. Hospice care services are payable for four 90-day periods. To be payable, the following criteria must be met:**

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- The following certifications are submitted to BCBSM:

  For the first 90 days of hospice care coverage:

  A written certification stating that the patient is terminally ill, signed by the:

  - Medical director of the hospice program **or**
  - Physician of the hospice interdisciplinary group **and**
  - Attending physician, if the patient has one

  For the second 90-day period (submitted no later than two days after this 90-day period begins):

  •

  The hospice must submit a **second** written certification of terminal illness signed by the:

  - Medical director of the hospice **or**
  - Physician of the hospice interdisciplinary group

  For the third 90-day period (submitted no later than two days after this 90-day period begins):

  The hospice must submit a **third** written certification of terminal illness signed by the:

  - Medical director of the hospice **or**
  - Physician of the hospice interdisciplinary group

  For the fourth 90-day period (submitted no later than two days after this 90-day period begins):

  The hospice must submit a **fourth** written certification of terminal illness signed by the:

  - Medical director of the hospice **or**
  - Physician of the hospice interdisciplinary group

**Hospice Care Services** (continued)

**We pay for:** (continued)

- The patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that hospice care has been fully explained to them. The waiver explains that BCBSM does not pay for treatment of the terminal illness itself or related conditions during hospice care.

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

**We pay for:**

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

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

Home Care Services

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

Facility Services

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

**Hospice Care Services** (continued)

**We pay for:** (continued)

Hospice Services

- Physician services by a member of the hospice interdisciplinary team
- Nursing care provided by, or under the supervision of, a registered nurse
- Medical social services by a licensed social worker, provided under the direction of a physician
- Counseling services to the patient and to caregivers, when care is provided at home
- BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)
- BCBSM-approved durable medical equipment furnished by the hospice program for use in the patient's home
- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

Professional Services

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

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

**How to Cancel Hospice Care Services**

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

**How to Reinstate Hospice Care Services**

Hospice care services may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

- Other than those furnished by the hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the patient's terminal illness.)
- Of a hospice program other than the one designated by the patient. (If the designated program arranges for the patient to receive the services of another hospice program, the services are covered.)
- That are not part of the plan of care established by the hospice program for the patient

## *Hospital Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For services in a long-term acute care hospital (LTACH), see Page 48.

The services in this section are in addition to all other services listed in this certificate that are payable in a participating hospital. An example would be surgery (see Page 109).

Locations: The following services are payable in a participating hospital or an approved outpatient location:

**We pay for:**

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

- Outpatient hospital services:

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

- Temporary Benefits for Hospital Services:

  If you are receiving services from a hospital that cancels its contract with BCBSM, you still have benefits. These temporary benefits end six months from the contract cancellation date. They include designated services, emergency care and travel and lodging. See Page 113 for more information.

## *Infertility Treatment*

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

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for infertility treatment in:

- A participating hospital, inpatient or outpatient
- A participating freestanding ambulatory surgery facility
- An office of a physician

**We pay for:**

Treatment of the underlying cause of infertility. Services include:

- Medically necessary diagnostic services
- Counseling services
- Planning services

**We do not pay for:**

Infertility services that treat infertility or that are intended to help a member to become pregnant. They include but are not limited to:

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

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

## *Infusion Therapy*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

BCBSM considers services from a participating infusion provider to be in-network. You will need to pay in-network cost-sharing for these services.

Locations: We pay for infusion therapy services:

- In an ambulatory infusion center or
- From a home infusion provider whether or not you are confined to the home (See Page 101 for when services may be payable in a nursing home.)

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

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care. For home infusion therapy, the condition must be able to be safely managed in the home
- Medically necessary (as defined in Section 7)
- Given by a **participating** infusion therapy provider

**We pay for:**

- Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy, please see the prior authorization for specialty pharmaceuticals requirement described on Page 88.
- Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care

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

  NOTE Except for chemotherapeutic drugs, services provided for infusion therapy under the home health care benefit are not covered separately elsewhere in this certificate.

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

## *Long-Term Acute Care Hospital Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for services provided in a long-term acute care hospital (LTACH) subject to the conditions described below.

**We pay for:**

The same services in a participating LTACH that we would pay for in a participating hospital.

The services are payable only if the following conditions are met:

- The long-term acute care hospital must
  - Be located in Michigan
  - Participate with BCBSM, except under extenuating circumstances as determined by BCBSM
- The provider must request and receive preapproval for inpatient services

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

**We do not pay for:**

- Services in a nonparticipating long-term acute care hospital, including emergency services, unless BCBSM determines there are extenuating circumstances
- Inpatient admissions that BCBSM has not preapproved
- LTACH services if the patient's primary diagnosis is a mental health or substance abuse condition

## *Maternity Care*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for facility and professional services in an inpatient hospital or approved birthing center for:

- Maternity care and related services
- Routine newborn nursery care during a mother's eligible hospital stay

Maternity services may be provided by in-network or out-of-network providers, subject to in-network or out-of-network deductible, coinsurance and copayment requirements (see Section 2).

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

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

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

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

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

**We pay for:**

- Obstetrics
  - Pre-natal care, including maternity education provided in a physician's office as part of a pre-natal visit

    NOTE

    Pre-natal visits conducted by an in-network provider are not subject to deductible, coinsurances or copayments. Diagnostic and laboratory tests performed in the physician's office are subject to deductible and coinsurance. See Section 2 beginning on Page 10 for what you may be required to pay for pre-natal visits conducted by an out-of-network provider.

  - Post-natal care, including a Papanicolau (Pap) smear during the six-week visit.

**Maternity Care** (continued)

**We pay for:** (continued)

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

  - Normal vaginal delivery when provided in:

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

- Newborn Examination

  We pay for a newborn's routine care during the mother's inpatient hospital stay. The exam must be given by a physician other than the anesthesiologist or the mother's attending physician.

  NOTE The baby must be eligible for coverage and must be added to your contract within 60 days of the birth.

**We do not pay for:**

- Lamaze, parenting or other similar classes.

## *Medical Supplies*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For medical supplies for outpatient diabetes treatment, see Page 66.
For medical supplies for infusion therapy, see Page 47.

Locations: We pay for medical supplies subject to the conditions described below, in:

- A hospital
- A hospice
- An outpatient facility
- A skilled nursing facility
- A physician's office or
- The home when provided by a BCBSM participating home health provider.

**We pay for:**

- Medical supplies and dressings used for the treatment of a specific medical condition. The quantity of medical supplies and dressings must be medically necessary. They include, but are not limited to:
- Gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Ostomy sets and accessories, catheterization equipment and urinary sets

Refer to Section 7 for the definition of "medically necessary."

## *Mental Health Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For autism disorders, please see Page 23.
For substance abuse treatment services, please see Page 107.
For emergency services to treat mental health conditions, please see Page 39.

Locations: We pay for mental health services in:

- A participating inpatient or outpatient hospital
- An approved inpatient psychiatric facility
- A participating residential psychiatric treatment facility
- A physician's, fully licensed psychologist's, Clinical Licensed Master's Social Worker's or licensed professional counselor's (LPC's) office
- An outpatient facility

NOTE

Mental health services are subject to deductible, copayment and coinsurance. Please see Section 2.

**We pay for:**

- **Inpatient mental health services (requires prior approval)**

  The following inpatient mental health services are payable when provided by a physician or by a fully licensed psychologist who has hospital privileges. When provided by a fully licensed psychologist who has hospital privileges, however, the services must be prescribed by a physician.

  - Individual psychotherapeutic treatment
  - Family counseling for members of a patient's family
  - Group psychotherapeutic treatment
  - Psychological testing prescribed or performed by a physician. The tests must be directly related to the condition for which the patient is admitted or have a full role in rehabilitative or psychiatric treatment programs
  - Electroshock therapy and its related anesthetics only when rendered by a physician
  - Inpatient consultations. If a physician needs help diagnosing or treating a patient's condition, we pay for inpatient consultations. They must be provided by a physician or fully licensed psychologist who has the skills or knowledge needed for the case.

- **Psychiatric residential treatment**

  **Psychiatric residential treatment** is covered only after it has been preauthorized by BCBSM or its representative. Covered services must be provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

  **We pay for:**

  - Services provided by facility staff
  - Individual psychotherapeutic treatment
  - Family counseling for members of a patient's family
  - Group psychotherapeutic treatment
  - Prescribed drugs given by the facility in connection with the member's treatment plan

  **We do not pay for:**

  - Staff consultations required by a facility's or program's rules
  - Marital counseling
  - Services provided by a facility located in Michigan that does not participate with BCBSM or by a facility located outside of Michigan that does not participate with its local Blue Cross/Blue Shield plan
  - An admission to a psychiatric residential facility or services by the facility that are not preauthorized before they occur. BCBSM or its representative must issue the preauthorization.

    - If preauthorization is not obtained:

      – A participating or in-network facility that provided the care cannot bill the member for the cost of the admission or services.
      – A nonparticipating or out-of-network facility that provided the care may require the member to pay for the admission and services.

  - Services that are not focused on improving the member's functioning
  - Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program
  - A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community
  - A residential program that serves to protect family members and other individuals in the member's living environment
  - Services to treat a disorder that is not amenable to favorable modification, according to generally accepted professional, evidence-based literature, such as certain personality disorders or certain types of intellectual impairment
  - Services or treatment that are cognitive in nature or supplies related to such services or treatment

**Mental Health Services** (continued)

**Psychiatric residential treatment** (continued)

**We do not pay for** (continued)

- Services, treatment, or supplies that are court-ordered or related to a court order
- Transitional living centers such as half-way and three-quarter way houses
- Therapeutic boarding schools
- Milieu therapies, such as wilderness program, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- Treatment or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a member under chemical influence when the member does not require medical treatment
- A private room or an apartment
- Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings and educational or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

- **Partial hospitalization services in a participating hospital.**

  **We pay for:**

  - Services provided by hospital staff
  - Ancillary services to patients who are admitted and discharged on the same day of treatment
  - Prescribed drugs given by the hospital in connection with the treatment plan
  - Electroshock therapy when administered by, or under the supervision of, a physician
  - Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy
  - Psychological testing
  - Family counseling

  For patients admitted to a psychiatric night treatment facility**, we also pay for**:

  - A semiprivate room
  - Nursing services and
  - Meals, including special diets

**Mental Health Services** (continued)

- **Outpatient Mental Health Services**

  We only pay for services in a **participating** outpatient mental health facility. (See Page 23 for special rules that apply to autism disorders.) We also pay for mental health services in an office setting (as applicable).

  **We pay for:**

  - Services provided by the facility's staff
  - Mental health services provided by a physician, fully licensed psychologist, clinical licensed master's social worker, licensed professional counselor or other professional provider as determined by BCBSM in an office setting or in a participating outpatient mental health facility:

    - Individual psychotherapeutic treatment of less than 20 minutes when provided only in a participating outpatient mental health facility
    - Individual psychotherapeutic treatment of more than 20 minutes
    - Family counseling for members of a patient's family
    - Group psychotherapeutic treatment
    - Psychological testing by:

      - A physician or a fully licensed psychologist or
      - A limited licensed psychologist when prescribed and performed under, and billed by, a physician or fully licensed psychologist

  - Family counseling for members of the patient's family
  - Ancillary services for patients who are admitted and discharged on the same day of treatment
  - Prescribed drugs given by the facility in connection with treatment

**We do not pay for:**

- Services provided by a nonparticipating hospital, inpatient facility or outpatient facility

- Services beyond the period required to evaluate or diagnose mental deficiency or developmental disability, or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

- Services provided in a skilled nursing facility or through a residential substance abuse treatment program

- Marital counseling

- Staff consultations required by a facility or program's rule

## *Occupational Therapy*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For physical therapy services, see Page 69.
For speech-language pathology services, see Page 103.
For autism disorders, see Page 23.

Locations: We pay for facility and professional occupational therapy services in the following locations subject to the conditions described below:

- A participating hospital, inpatient or outpatient

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

- A participating freestanding outpatient physical therapy facility
- An office of a physician or an independent occupational therapist
- A participating skilled nursing facility
- The patient's home (see Page 101 for when services may be payable in a nursing home)

**We pay for:**

NOTE Special rules apply when physical therapy, occupational therapy or speech and language pathology services are provided to treat autism. Please see Autism Disorders on Page 23.

- Medically necessary occupational therapy services when you are an inpatient in a hospital or skilled nursing facility subject to conditions described further down in this section
- A **combined** maximum of 30 outpatient visits per member per year.

**Important:** **See Note below about treatment dates and initial evaluations. This 30 visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:**

- **Occupational therapy**
- **Physical therapy (includes physical therapy by a chiropractor)**
- **All chiropractic manipulations**
- **Osteopathic manipulative therapy**

**Occupational Therapy** (continued)

**We pay for:** (continued)

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

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

Occupational therapy must be:

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

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

  - For outpatient services: an athletic trainer under the direct supervision of an occupational therapist in an outpatient setting

**We do not pay for:**

- More than 30 outpatient visits per member per calendar year, (see above about combined benefit) whether obtained from an in-network or out-of-network provider
- Therapy to treat long standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without an occupational therapy treatment plan that guides and helps to monitor the provided therapy
- Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program

**Occupational Therapy** (continued)

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

- Services received from a nonparticipating hospital or freestanding outpatient physical therapy facility
- Services received from other facilities independent of a hospital
- Services received from an independent sports medicine clinic
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

  NOTE

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

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

- Recreational therapy
- Patient education and home programs

## *Office Visits*

*See Page 15 in Section 2 for what you may be required to pay for these services.*

For chiropractic or osteopathic office visits for spinal manipulation, please see Page 28.

Locations: We pay for office visits in a provider's office to an in-network physician or eligible professional provider.

Office visits include:

- Office consultations
- Presurgical consultations
- Outpatient visits
- Home visits
- Provider-Delivered Care Management office visits

  NOTE Office visits for pre- and post-natal care are payable. Pre-natal visits to an in-network provider are not subject to cost-sharing. See Section 2 for what you may have to pay for post-natal visits or pre-natal visits to an out-of-network provider.

- Specialist office visits

  NOTE Only medically necessary services are payable.

**We do not pay for:**

- Out-of-network office visits

## *Oncology Clinical Trials*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For general surgery services, see Page 109.
For transplant services, see Page 117.

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

Benefits for specified oncology clinical trials provide coverage for:

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

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

**Mandatory Preapproval**

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

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

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

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

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

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

**Oncology Clinical Trials** (continued)

**Mandatory Preapproval** (continued)

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

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

Preapproval will be granted if:

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

**We pay for:**

- Chemotherapeutic drugs. If Michigan law requires it, we cover these drugs and the reasonable cost of giving them.
- Immunizations. We pay for vaccines against infection during the first 24 months after a transplant as recommended by the ACIP (Advisory Committee on Immunization Practices).
- **Autologous Transplants**
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
  - Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization

**Oncology Clinical Trials** (continued)

**We pay for** (continued)

- **Allogeneic Transplants**

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

    - Bone marrow
    - Peripheral blood stem cell (including peripheral blood stem cell pheresis)
    - Umbilical cord blood

    NOTE The recipient of harvested material must be a BCBSM member.

  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
  - T cell depleted infusion
  - Donor lymphocyte infusion
  - Hospitalization

- **Travel and Lodging**

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

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

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

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

**Oncology Clinical Trials** (continued)

**We do not pay for:**

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

**Oncology Clinical Trials** (continued)

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

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

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

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

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

## *Optometrist Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

**We pay for:**

Services performed by a licensed optometrist within the scope of his or her license and subject to the conditions described below.

- Services must be medically necessary. Refer to Section 7 for the definition of "medically necessary."
- The optometrist must provide the covered services within the state of Michigan.
- The optometrist must be:
  - Licensed in the state of Michigan
  - Certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents
- If you get services from an optometrist who does not participate in BCBSM's vision program, they will be treated as services of a nonparticipating provider.

**We do not pay for:**

- Routine eye exams or services

## *Outpatient Diabetes Management Program*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for services provided in a home or (for training) in a group setting subject to the conditions described below.

**We pay for:**

Selected services and medical supplies to treat and control diabetes when:

- Determined to be medically necessary
- Prescribed by an M.D. or D.O.

Refer to Section 7 for the definition of "medically necessary".

Diabetes services and medical supplies include:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Insulin pumps
- Test strips for glucose monitors
- Visual reading and urine test strips
- Lancets
- Spring-powered lancet devices
- Syringes
- Insulin
- Medical supplies required for the use of an insulin pump
- Nonexperimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
- Diabetic specialty shoes

**Outpatient Diabetes Management Program** (continued)

Diabetes services and medical supplies include: (continued)

- Diabetes self-management training conducted in a group setting, whenever practicable, if:
  - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
  - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
  - The provider of self-management training must be:
    - Certified to receive Medicare or Medicaid reimbursement **or**
    - Certified by the Michigan Department of Community Health.

## *Pain Management*

For infusion therapy services, see Page 47.

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

Locations: We pay for services to manage pain in:

- An inpatient and/or outpatient participating hospital setting
- An approved participating outpatient facility
- A physician's office

**We pay for:**

- Covered services and devices for pain management when medically necessary as documented by a physician
- Covered services performed by a certified registered nurse anesthetist

**We do not pay for:**

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

## *Physical Therapy*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For physical therapy services provided in a home, see Page 40.

For occupational therapy services, see Page 56.

For speech-language pathology services, see Page 103.

For autism disorders, see Page 23.

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

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

- A participating hospital, inpatient or outpatient

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

- A participating skilled nursing facility

- A freestanding outpatient physical therapy facility

  NOTE For freestanding facilities, we pay the facility directly for the service, not the individual provider who rendered the service.

- An office of a physician, chiropractor, or an independent physical therapist

- The patient's home (see page 101 for when services may be payable in a nursing home)

**We pay for:**

Medically necessary physical therapy services subject to the following:

NOTE Special rules apply when physical therapy, occupational therapy or speech and language pathology services are provided to treat autism. Please see Autism Disorders on Page 23.

- A **combined** maximum of 30 outpatient visits per member per year.

**Important:** **See Note below about treatment dates and initial evaluations. This 30 visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:**

- **Occupational therapy**
- **Physical therapy (includes physical therapy by a chiropractor)**
- **All chiropractic manipulations**
- **Osteopathic manipulative therapy**

**Physical Therapy** (continued)

**We pay for:** (continued)

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

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

- Physical therapy must be:
  - Prescribed by a physician licensed to prescribe it or by a physician assistant who is supervised by a physician unless prescribed by a chiropractor (See page 28)
  - Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
  - Given by the approved providers in the locations listed below:

| Locations | Providers |
|---|---|
| • A hospital, inpatient or outpatient<br>• A skilled nursing facility<br>• A freestanding outpatient physical therapy facility<br>• A provider's office<br>• A member's home<br>• A nursing home if it is the member's primary residence | • A doctor (M.D., D.O. or a podiatrist)<br>• A dentist or optometrist<br>• A chiropractor<br>• A physical therapist, physical therapist assistant, or athletic trainer<br>• A physician's assistant<br>• A certified nurse practitioner |

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

**Physical Therapy** (continued)

**We do not pay for:**

- More than 30 outpatient visits per member per calendar year (see above about combined benefit), whether obtained from an in-network or out-of-network provider.
- Services received from a nonparticipating hospital, freestanding outpatient physical therapy facility or any other facility independent of a hospital or in an independent sports medicine clinic
- Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a physical therapy treatment plan that guides and helps to monitor the provided therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a physical therapy treatment plan that guides and helps to monitor the provided therapy

  NOTE

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

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

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

## *Prescription Drugs*

For chemotherapy services, see Page 26.

For contraceptive services, see Page 91.

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

Locations: We pay for prescribed drugs you get from a pharmacy, in a hospital or other approved locations. These are subject to the conditions described below.

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

- Outpatient facilities
- Office
- Clinic
- Home

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

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

We will notify you If prior authorization is requested, but is not approved by BCBSM and you have the right to appeal under applicable law. If the prior authorization is not approved via the appeal, you will be responsible for the full cost of the specialty pharmaceuticals.

- **Prescription Drug Program – Drugs Received from a Pharmacy**

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

We pay for each covered drug and each refill of a covered drug as dispensed by an in-network pharmacy as follows:

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

We will cover at least the greater of:

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

We reserve the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. We also reserve the right to limit select controlled substances to no more than a 15-day supply for the initial fill. Your copayment will be reduced by one-half (1/2) for each fill that has been limited to a 15-day supply once applicable deductibles have been met

If your physician switches your brand-name drug to a comparable generic drug, you may not have to pay your first copayment. After this initial period, you only have to pay a generic copayment for the generic drug.

If your plan has a deductible, the copayment will not be waived unless you have met your deductible.

**Prescription Drug Program** (continued)

**We pay for:**

Contraceptive Drugs

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

| If your physician prescribes a contraceptive drug for the time period of: ↓ | And you obtain the drug through: | | | |
|---|---|---|---|---|
| | 90-Day Retail In-network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) | Out-of-network Pharmacy |
| 1 – 30 days | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | We pay 80% of the approved amount for **generic** and select brand name drugs **before integrated in-network deductible,** you pay a 20% penalty and any amount over our approved amount**;** You pay member cost-sharing as described further down this certificate for other **brand name** drugs plus a 20% penalty and any amount over our approved amount |
| 31 – 60 days | BCBSM does not cover it | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |
| 61 – 83 days | BCBSM does not cover it | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |
| 84 – 90 days | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |

NOTE

Important: We pay 100 percent of the approved amount for **generic** and select **brand name** drugs **before integrated deductible;** you pay member cost-sharing as described further down in this section for other **brand name** drugs

When a BCBSM in-network pharmacy fills a prescription for most other brand-name contraceptives, we will pay the pharmacy 100 percent of the approved amount if your physician receives prior authorization from BCBSM. Prior authorization will depend on medical necessity, the patient's current medical information, and criteria approved by BCBSM. For example, previous treatment with one or more preferred drugs may be required.

Preventive Drugs, Supplements and Vitamins

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

- Preventive drugs
- Supplements
- Vitamins

  This may include coverage for:

  - Folic acid
  - Iron supplements
  - Fluoride supplements
  - Aspirin
  - Smoking cessation drugs

However, we reserve the right to only pay for over-the-counter versions of any drugs, vitamins and supplements required to be covered under this Act.

To be covered, preventive drugs, supplements and vitamins must be:

- Prescribed by a physician
- Approved by the FDA, when FDA approval is available **and**
- Meet coverage criteria required under the Patient Protection and Affordable Care Act.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Preventive Drugs, Supplements and Vitamins (continued)

| If your physician prescribes a preventive drug, supplement or vitamin for the time period of: ↓ | And you obtain the drug, supplement or vitamin through: | | | |
|---|---|---|---|---|
| | 90-Day Retail In-network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) | Out-of-network Pharmacy |
| 1 – 30 days | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | We pay 80% of the approved amount for **generic** and select brand name drugs **before integrated in-network deductible,** you pay a 20% penalty and any amount over our approved amount**;** You pay member cost-sharing as described further down this certificate for other **brand name** drugs plus a 20% penalty and any amount over our approved amount |
| 31 – 60 days | BCBSM does not cover it | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |
| 61 – 83 days | BCBSM does not cover it | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |
| 84 – 90 days | We pay 100% of the approved amount* (see NOTE below) | We pay 100% of the approved amount* (see NOTE below) | BCBSM does not cover it | BCBSM does not cover it |

NOTE

Important: We pay 100 percent of the approved amount for **generic** and select **brand name** drugs **before integrated deductible;** you pay member cost-sharing as described further down in this section for other **brand name** drugs

When a BCBSM in-network pharmacy fills a prescription for most other brand-name drugs or services that are federally mandated, we will pay the pharmacy 100 percent of the approved amount, but only if your physician receives prior authorization from BCBSM. Prior authorization will depend on medical necessity, the patient's current medical information, and criteria approved by BCBSM. For example, previous treatment with one or more preferred drugs may be required.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Generic Drugs

Your copayment for each covered generic drug is as described below:

| If your physician prescribes a generic drug for the time period of: ↓ | And you obtain the drug through: | | |
|---|---|---|---|
| | 90-Day Retail Network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) |
| 1 – 30 days | You pay $15 per prescription, after integrated deductible | You pay $15 per prescription, after integrated deductible | You pay $15 per prescription, after integrated deductible |
| 31 – 60 days | BCBSM does not cover it | You pay $30 per prescription, after integrated deductible | BCBSM does not cover it |
| 61-83 days | BCBSM does not cover it | You pay $45 per prescription after integrated deductible | BCBSM does not cover it |
| 84 – 90 days | You pay $45 per prescription, after integrated deductible | You pay $45 per prescription, after integrated deductible | BCBSM does not cover it |

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

The following circumstances do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail-order provider.
- Payment for noncovered drugs.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Preferred Brand-Name Drugs

Your copayment for each covered preferred brand name drug is as described below, even if:

- Your prescription is marked "DAW";
- There is no generic equivalent drug available.

For a brand-name drug on our preferred drug list, the minimum copayment you will be responsible for is $40. Your copayment for preferred brand name drugs is as follows:

| If your physician prescribes a preferred brand name drug for the time period of: ↓ | And you obtain the drug through: | | |
|---|---|---|---|
| | 90-Day Retail Network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) |
| 1 – 30 days | You pay 25% with a $40 minimum and $100 maximum per prescription, after integrated deductible | You pay 25% with a $40 minimum and $100 maximum per prescription, after integrated deductible | You pay 25% with a $40 minimum and $100 maximum per prescription, after integrated deductible |
| 31 – 60 days | BCBSM does not cover it | You pay 25% with an $80 minimum and $200 maximum per prescription, after integrated deductible | BCBSM does not cover it |
| 61 – 83 days | BCBSM does not cover it | You pay 25% with a $120 minimum and $300 maximum per prescription, after integrated deductible | BCBSM does not cover it |
| 84 – 90 days | You pay 25% with a $120 minimum and $300 maximum per prescription, after integrated deductible | You pay 25% with a $120 minimum and $300 maximum per prescription, after integrated deductible | BCBSM does not cover it |

If the approved amount of the drug is less than your specified minimum copayment, then you pay only the approved amount of the drug.

The following circumstances do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail-order provider.
- Payment for noncovered drugs.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Non-Preferred Brand-Name Drugs

Your copayment for each covered non-preferred brand name drug is as described below, even if:

- Your prescription is marked "DAW";
- There is no generic equivalent drug available.

For a non-preferred brand name drug, the minimum copayment you will be responsible for is $80.

Your copayment for each covered non-preferred brand name drug is as follows:

| If your physician prescribes a nonpreferred brand name drug for the time period of: ↓ | And you obtain the drug through: | | |
|---|---|---|---|
| | 90-Day Retail Network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) |
| 1 – 30 days | You pay 50% with an $80 minimum and $100 maximum, per prescription after integrated deductible | You pay 50% with an $80 minimum and $100 maximum, per prescription after integrated deductible | You pay 50% with an $80 minimum and $100 maximum, per prescription after integrated deductible |
| 31 – 60 days | BCBSM does not cover it | You pay 50% with a $160 minimum and $200 maximum, per prescription after integrated deductible | BCBSM does not cover it |
| 61 – 83 days | BCBSM does not cover it | You pay 50% with a $240 minimum and $300 maximum, per prescription after integrated deductible | BCBSM does not cover it |
| 84 – 90 days | You pay 50% with a $240 minimum and $300 maximum, per prescription after integrated deductible | You pay 50% with a $240 minimum and $300 maximum, per prescription after integrated deductible | BCBSM does not cover it |

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

The following circumstances do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail-order provider.
- Payment for noncovered drugs.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Generic and Preferred Brand-name Specialty Drugs

Your copayment for each covered generic and preferred brand name specialty drug is as described below, even if:

- Your prescription is marked "DAW";
- There is no generic equivalent drug available.

For generic and preferred brand name specialty drugs, the minimum copayment you will be responsible for is 20 percent of the approved amount.

Your copayment for generic and preferred brand name specialty drugs is as follows:

| If your physician prescribes a generic or preferred brand name specialty drug for the time period of: ↓ | And you obtain the drug through: | | |
|---|---|---|---|
| | 90-Day Retail Network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) |
| 1 – 30 days | You pay 20% of the approved amount, but no more than $200 after integrated deductible | You pay 20% of the approved amount, but no more than $200 after integrated deductible | You pay 20% of the approved amount, but no more than $200 after integrated deductible |
| 31 – 83 days | BCBSM does not cover it | BCBSM does not cover it | BCBSM does not cover it |
| 84 – 90 days | BCBSM does not cover it | BCBSM does not cover it | BCBSM does not cover it |

All specialty drug copayments are limited to the contract's integrated out-of-pocket maximum. Once the out-of-pocket maximum is met, prescription drugs will be covered by BCBSM at 100 percent of the approved amount.

The following circumstances do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Amounts that exceed our approved amount for covered specialty drugs or out-of-network retail penalty amounts.
- Specialty drugs obtained from an out-of-network mail-order provider.
- Payment for noncovered specialty drugs.

**Prescription Drug Program** (continued)

**We pay for:** (continued)

Non-preferred Brand-Name Specialty Drugs

Your copayment for each covered nonpreferred brand name specialty drug is as described below, even if:

- Your prescription is marked "DAW";
- There is no generic equivalent drug available.

For a nonpreferred brand name specialty drug, the minimum copayment you will be responsible for is 25 percent of the approved amount.

Your copayment for nonpreferred brand name specialty drugs is as follows:

| If your physician prescribes a nonpreferred brand name specialty drug for the time period of: ↓ | And you obtain the drug through: | | |
|---|---|---|---|
| | 90-Day Retail Network Pharmacy | In-network Mail Order Provider | In-network Pharmacy (not part of the 90-Day Retail Network) |
| 1 – 30 days | You pay 25% of the approved amount, but no more than $300 after integrated deductible | You pay 25% of the approved amount, but no more than $300 after integrated deductible | You pay 25% of the approved amount, but no more than $300 after integrated deductible |
| 31 – 83 days | BCBSM does not cover it | BCBSM does not cover it | BCBSM does not cover it |
| 84 – 90 days | BCBSM does not cover it | BCBSM does not cover it | BCBSM does not cover it |

NOTE

All specialty drug copayments are limited to the contract's integrated out-of-pocket maximum. Once the out-of-pocket maximum is met, prescription drugs will be covered by BCBSM at 100 percent of the approved amount.

The following circumstances do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Amounts that exceed our approved amount for covered specialty drugs or out-of-network retail penalty amounts.
- Specialty drugs obtained from an out-of-network mail-order provider.
- Payment for noncovered specialty drugs.

Covered drugs obtained from out-of-network retail pharmacies continue to be subject to any additional cost-sharing requirements described in your benefit package.

NOTE

If the approved amount of a generic, brand-name or specialty drug is less than your copayment, then you pay only the approved amount of the drug.

**Prescription Drug Program** (continued)

Mandatory Prior Authorization

For some drugs, certain clinical criteria must be met before coverage is provided. In the case of drugs requiring step therapy, for example, previous treatment with one or more preferred drugs may be required. A list of drugs that may require prior authorization or step therapy is available at the BCBSM website at **bcbsm.com**. We will pay for each drug and each refill of a drug prescribed by a physician, as follows:

Some drugs require prior authorization from BCBSM before we will pay for them. If prior authorization is not requested or received from us, we will not pay for the drug. You will be responsible for 100 percent of the pharmacy's charge.

We will pay our approved amount for select prescription drugs obtained from a pharmacy or in-network mail order provider if both of the following are met:

- The prescribing physician requests prior authorization and demonstrates that the drug meets BCBSM's prior authorization criteria.

- We approve the request.

NOTE

If we approve the request, you will still need to pay cost-sharing as noted in your coverage.

Requests for Drugs Not on BCBSM's Drug List

Your prescription drug coverage is limited to an approved drug list. If your drug is not on the approved drug list, you may request an exception. BCBSM must approve your request for a drug not on the list before it is dispensed. If approval is not obtained before the drug is dispensed, the drug will not be covered.

To request an exception, you must follow BCBSM's exception request process. The process is as follows:

- You, your designee or the provider who prescribed you the drug must contact BCBSM and request an exception for the drug that is not on BCBSM's approved drug list.

- We will decide whether to grant the request once we receive all of the information we need to make a decision. We will notify you, your designee, the prescribing provider or the provider's designee whether the request has been granted within 24 hours of receiving all of the needed information.

**Requests for Drugs Not on BCBSM's Drug List** (continued)

**If the request is** based on exigent circumstances, the prescribing physician or other prescriber **must submit an** oral or written statement that:

- An exigency exists
- The reason for the exigency
- Why the member must have the requested drug, including a statement that all other drugs on the drug list:
  - Will be or have been ineffective,
  - Would not be as effective as the requested drug, or
  - Would have adverse effect on the member

For the request to be approved, the drugs must:

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

If your physician does not get approval before the drug is dispensed, the drug will not be covered. If the exception request is approved, you will have to pay your cost-sharing as noted in your coverage.

To learn more about this process, visit **bcbsm.com** or call the Customer Service number on the back of your card.

Chemotherapy Specialty Pharmaceuticals

There are certain chemotherapy specialty drugs that need our preauthorization for us to pay for them. We only pay for these drugs when you get them from an in-network pharmacy that we identify.

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

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

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

If preauthorization is not requested and received from us, we will not pay for the drug. You will be responsible for 100 percent of the phamacy's charge.

**Prescription Drug Program** (continued)

**How to File a Claim**

If an in-network pharmacy required you to pay for a prescription, or if you disagree with the amount you had to pay for a prescription, you may submit to us a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, please refer to the "How to Reach Us" section at the back of this certificate. Or check our website at **bcbsm.com**.

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

When an out-of-network pharmacy fills a prescription for a covered drug, you must pay the pharmacist the full cost of the drug and submit to us a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, please refer to the "How to Reach Us" section at the back of this certificate. Or check our website at **bcbsm.com**.

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

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

For covered drugs obtained outside of the United States, we will reimburse you 100 percent of the approved amount, minus your copayment.

**Prescription Drugs Not Covered**

- We do not pay for:
  - Contraceptive medications and devices not required to be covered under the Patient Protection and Affordable Care Act.
  - Brand-name drugs when a generic equivalent is available (multi-source brand)
  - Therapeutic devices or appliances, including, but not limited to hypodermic or disposable needles and syringes when not dispensed with the following:
  - A covered injectable drug,
  - Insulin
  - Self-administered chemotherapeutic drugs.
  - Drugs prescribed for cosmetic purposes
  - The charge for:
    - Any prescription refill that is more than the number specified by the prescriber or
    - Any refill dispensed one year after prescription was written
  - Any vaccine given solely to resist infectious diseases, unless required to be covered under the Patient Protection and Affordable Care Act

**Prescription Drug Program** (continued)

**Prescription Drugs Not Covered** (continued)

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

- More than a 30-day supply of a covered drug unless dispensed by an In-Network Retail 90 pharmacy or In-Network Mail Order pharmacy. We may make exceptions for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

NOTE

A 30-day supply limitation applies to prescription drugs that BCBSM defines as "specialty pharmaceuticals." We will not pay for more than a 30-day supply of a covered specialty pharmaceutical. We may make exceptions if a member requires more than a 30-day supply.

- Drugs obtained from out-of-network mail-order providers, including Internet providers.
- Prescriptions for quantities of 84 through 90 days that are not provided by a 90-Day Retail Network provider or an in-network BCBSM mail order provider.
- More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains prior authorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM website at bcbsm.com.
- Any drug we think is experimental or investigational

NOTE

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

- State-controlled drugs
- Any covered drug entirely consumed at the time and place of the prescription
- Administration of covered drugs (e.g., injections)
- Anything other than covered drugs and services
- Diagnostic agents
- Drugs that are not labeled "FDA approved," except for insulin, or such drugs that BCBSM designates as covered
- Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device. (However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it was prescribed. See criteria under "Covered Drug" in Section 7.)
- Covered drugs or services that are covered under a medical benefit in a BCBSM certificate you have.
- Drugs or services obtained before the effective date of this contract, or after the contract ends
- Claims for covered drugs or services submitted after the applicable time limit for filing claims (see Page 151)
- Support garments or other nonmedical items
- Compounded drugs that contain any bulk chemical powders or ingredients that are not approved by BCBSM
- Over the counter drugs unless coverage is required under the Patient Protection and Affordable Care Act or not considered a covered service

**Prescription Drug Program** (continued)

**Prescription Drugs Not Covered** (continued)

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

- Prescription drugs with comparable products available over-the-counter, including but not limited to, cough/cold products
- Lifestyle drugs – drugs used for weight loss or erectile dysfunction
- Compounded hormones
- Select high abuse drugs
- Dietary supplements
- Drugs newly approved by the FDA until review and coverage determination by BCBSM
- Non-self-administered injectable drugs
- Certain drugs that may not be covered based on recommendations from BCBSM

NOTE

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

- Elective Abortions: Services, devices, drugs or other substances provided by a pharmacy that are prescribed to terminate a woman's pregnancy for a purpose other than to: preserve the life or health of the child after a live birth; remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Any service, device, drug or other substance related to an elective abortion is also excluded.

NOTE

Elective abortions do not include:

  – Services, devices, drugs or other substances provided by a physician to terminate a woman's pregnancy because her physical condition, in the physician's reasonable medical judgment, requires that her pregnancy be terminated to avert her death; and
  – Treatment of a woman experiencing a miscarriage or who has been diagnosed with an ectopic pregnancy.

- Services related to an elective abortion are also excluded.

**Drugs Received in a Hospital (Inpatient or Outpatient)**

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

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

**Prescription Drug Program** (continued)

**Drugs Received in a Hospital (Inpatient or Outpatient)** (continued)

- Drugs are also payable:

  - In a participating freestanding ambulatory surgery facility when directly related to surgery (see Page 112)
  - In a participating freestanding ESRD facility in conjunction with dialysis services (see Page 35)
  - In a participating skilled nursing facility (see Page 101)
  - As part of home health services when services are provided by a participating hospital (see Page 40)
  - When required for infusion therapy (see Page 47)
  - In a participating hospice for the comfort of the patient (see Page 41)
  - In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program (see Page 52).

**Drugs Administered by a Physician**

- **Injectable Drugs:** We pay for covered drugs or biologicals that are injected. We also pay for their administration. The injectable drugs and biologicals must be:

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

- **Specialty Pharmaceuticals:** We pay for covered specialty drugs administered by an in-network or participating professional provider.

  - We pay for the drug and its administration when ordered and billed by the physician, or
  - We pay for the drug when billed by the specialty pharmacy provider and we pay the physician for administration of the drug.

- **Hemophilia Medication**

  We will pay for hemophilia factor product when you get it from one of the following professional providers:

  – In-network providers
  – Out-of-network providers
  – Participating providers
  – Nonparticipating providers

  See Section 7 "Definitions" for the definition of professional providers.

  We will pay for supplies for the infusion of the hemophilia factor product. If you buy them from a participating provider, we will pay the provider directly. If you buy them from a nonparticipating provider, we will pay you and you will need to pay the nonparticipating provider.

## Prior Authorization for Specialty Pharmaceuticals

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

- Outpatient facilities
- Office
- Clinic
- Home

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

- If your physician asks for prior authorization, but it is not approved by BCBSM, you have the right to appeal under applicable law. If the prior authorization is not approved through the appeal, you will be responsible for the full cost of the specialty drug.
- If your physician does not get prior authorization, BCBSM will deny the claim and you will be responsible for the full cost of the specialty drug.
- If your physician did not get prior authorization and you appeal the denial of the claim, BCBSM will review it to determine if the benefits can be paid. If BCBSM upholds the denial, you have the right to appeal under applicable law.

## *Preventive Care Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

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

Preventive care services are covered only when performed by an in-network provider. Services received from an out-of-network provider are not covered. This section describes what we cover for all preventive care services.

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

- A participating outpatient hospital or participating facility (e.g., an ambulatory surgery center)
- A participating inpatient hospital
- A professional provider's office

We will also pay an independent laboratory to analyze a test.

**We pay for:**

We pay 100 percent of our approved amount for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by in-network providers.

Deductibles, coinsurance or copayments are not required for these services when performed by an in-network provider.

- Health Maintenance Examination

  One exam per member, per calendar year. This is a full history and physical exam. It includes taking your blood pressure, looking for skin malignancies, a breast exam, a testicular exam, a rectal exam and health counseling about any potential risk factors you may encounter.

- Flexible Sigmoidoscopy Examination

  One routine flexible sigmoidoscopy examination per member, per calendar year

- Gynecological Examination

  One routine gynecological examination per member, per calendar year

- Fecal Occult Blood Screening

  One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool

**Preventive Services** (continued)

**We pay for:** (continued)

- Screening Mammography

  We pay for one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer.

  Subsequent medically necessary mammographies performed during the same calendar year by an in-network or out-of-network provider are subject to your deductible and coinsurance requirements.

- Well-Baby and Child Care Visits

  We pay for well-baby and child care visits through age 18 as follows:

  - Eight visits for children from birth through 12 months
  - Six visits for children 13 months through 23 months
  - Two visits for children 24 months through 35 months
  - Two visits for children 36 months through 47 months
  - One visit per year for children 48 months through age 18

- Immunizations

  We pay for childhood immunizations through the age of 18 years and adult immunizations. We follow the recommendations of the Advisory Committee on Immunization Practices. We may also follow other sources as known to BCBSM.

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

- Routine Laboratory Services

  We pay for the following services once per member, per calendar year, when performed as routine screening:

  - Chemical profile
  - Cholesterol testing

- Colonoscopy

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

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

**Preventive Services** (continued)

**We pay for:** (continued)

- Morbid Obesity Weight Management
  - For a member with a BMI of 30 or above, we pay for 26 visits per member per calendar year. Visits can include nutritional counseling, such as dietician services, billed by a physician or other provider recognized by BCBSM.
- Tobacco Cessation Programs
  - We will pay for screening, counseling and prescription drugs to help you stop smoking.
- Women's Preventive Care Contraceptive Services

For contraceptive medications other than injectable drugs, see Page 74.

- Voluntary Sterilization for Females

  We pay for hospital and physician benefits for voluntary sterilizations for females, including, but not limited to, tubal ligation.

- Contraceptive Devices

  We pay for a contraceptive device requiring a prescription by a physician or other legally authorized professional provider and for the insertion and removal of an intrauterine device by a licensed physician or a licensed certified nurse midwife (CNM) or other eligible provider.

  Devices may include, but are not limited to:

  - Diaphragms
  - Intrauterine devices
  - Contraceptive implants

- Contraceptive Injections

  We pay our approved amount for contraceptive injections given by a physician or a CNM or other legally authorized professional provider, including the cost of the medication when provided by the physician, a CNM or other eligible provider.

- Genetic Testing

  We pay for BRCA and Rh(D) testing in addition to HPV, HIV and cervical cancer screening for pregnant women.

**Preventive Services** (continued)

**We do not pay for:**

- Screening and preventive services that are:
  - Not listed in this certificate or
  - Not required to be covered under PPACA. To see a complete list of the services and immunizations that must be covered under PPACA ,go to https://www.healthcare.gov/preventive-care-benefits/children/

  You may also contact BCBSM customer service.

## *Professional Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

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

- **Certified Nurse Practitioner Services:** We pay for the covered services that are provided by a certified nurse practitioner.

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

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

  NOTE Outpatient consultations in an in-network physician's office are subject to cost-sharing requirements. Out-of-network physician office consultations are not covered. See Section 2.

## *Prosthetic and Orthotic Devices*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For durable medical equipment services, see Page 37.

Locations: We pay for prosthetic and orthotic devices while you are in a participating hospital or for use outside of the hospital. Our payment is based on meeting the conditions described below.

**We pay for:**

Prosthetic and orthotic devices:

- Prescribed by a physician or certified nurse practitioner
- Permanently implanted in the body or
- Used externally as part of regular hospital equipment

The prescription must include a description of the equipment and the reason for the need or the diagnosis.

Covered services include:

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

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

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

**Prosthetic and Orthotic Devices** (continued)

Coverage Guidelines

BCBSM covers external prosthetic and orthotic devices that are payable by Medicare Part B. They are covered as of the date they were purchased or rented. In some cases BCBSM guidelines may be different from those of Medicare Part B. Please call your local customer service center for specific coverage information.

To be covered, custom-made devices must be furnished:

- By a fully accredited provider

**We pay for:** (continued)

- With BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC).

Prosthetic and orthotic suppliers may include:

- M.D.s, D.O.s,
- Podiatrists,
- Prosthetists
- Orthotists

All suppliers must meet BCBSM qualification standards.

NOTE An optometrist who is also a prosthetist may only provide ocular prostheses.

Provider Limitations

If a provider is participating with BCBSM but is not accredited by ABC, only the following devices are covered:

- External breast prostheses following a mastectomy which include:
  - Two post-surgical brassieres and
  - Two brassieres in any 12-month period thereafter
  - Additional brassieres are covered if they are required:
    - Because of significant change in body weight
    - For hygienic reasons
- Prefabricated custom-fitted orthotic devices

**Prosthetic and Orthotic Devices** (continued)

Provider Limitations (continued)

- Artificial eyes, ears, noses and larynxes
- Prescription eyeglasses or contact lenses after cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Optometrists may provide these lenses.
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses (as defined in Section 7) that have been approved by BCBSM. Dentists may provide you with these devices.
- If you have an urgent need for an item that is not custom-made (e.g., wrist braces, ankle braces, or shoulder immobilizers), we will pay for the item to be provided by an M.D., D.O., or podiatrist. Please call your local customer service center for information on which devices are covered.

**We do not pay for:**

- Hair prostheses such as wigs, hair pieces, hair implants, etc.
- Spare prosthesis devices
- Routine maintenance of a prosthetic device
- Experimental prosthetic devices
- Prosthetic devices ordered or purchased before the effective date of this coverage under this certificate.

## *Provider-Delivered Care Management*

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

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

PDCM services are covered only when they are performed by designated in-network providers. A care manager is a trained clinician, such as a registered nurse, clinical licensed masters of social worker, certified nurse practitioner or physician assistant. This section describes what we cover for all PDCM services.

Locations: We pay for professional services for PDCM in the following locations:

- A professional provider's office
- A participating outpatient hospital or participating facility
- A patient's home
- Other locations as designated by BCBSM or an out-of-state Blue Cross plan

**We pay for:**

Certain care management services identified by BCBSM are provided to BCBSM members, only when performed by:

- In-network BCBSM-designated providers in Michigan
- Out-of-state providers who are designated by their local Blue Cross/Blue Shield plan to provide care management services

There are no deductibles, copayments and coinsurances for these in-network services. Out-of-network services are not covered.

PDCM services may include:

- Telephonic interventions and individual and face-to-face group visits
- Medication assessments to make clear:
  - The appropriateness of the drug
  - The correct dosage
  - When to take it
  - To identify potential conflicts
    - Care transitions after a hospital discharge to be sure you understand the discharge instructions and your follow-up with your primary care physician
    - Action plans that help you manage your health better and set goals for improvement

Most PDCM services include support for setting goals and managing your participation. We encourage in-person contact between you and your care managers. Services are subject to change.

**Provider-Delivered Care Management** (continued)

**Eligibility**

You are eligible to receive PDCM services if you have:

- Active BCBSM coverage
- One or more conditions that indicate that care management services have the potential to improve well-being
- Agreed to actively participate with PDCM
- A referral for care management services from a physician

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

  - Diagnosis
  - Admission status
  - Clinical status

**Termination of Provider- Delivered Care Management**

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

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

**We do not pay for:**

Services provided that are not designated as PDCM services

NOTE For more information on PDCM services, contact BCBSM customer service.

## *Radiology Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For radiology services in an ambulatory surgical facility, see Page 112.

Locations: We pay for hospital, facility and physician diagnostic and therapeutic radiology services in:

- A participating hospital, inpatient or outpatient, or participating outpatient facility
- A BCBSM-approved physician's office

**We pay for:**

Diagnostic Radiology Services

- We pay for facility and physician diagnostic radiology services. These services are used to diagnose disease, illness, pregnancy or injury. The services must be provided by your physician or by another physician if agreed on by your physician:
  - X-rays
  - Radioactive isotope studies and use of radium
  - Ultrasound
  - Computerized axial tomography (CAT) scans
  - Magnetic resonance imaging (MRI)
  - Positron emission tomography (PET) scans
  - Medically necessary mammography
  - Nuclear cardiac studies

NOTE

Mammography services (other than for routine screening – see Page 90) are payable **only** when your physician prescribes them because of suspected or actual presence of a disease, or when performed as a postoperative procedure.

Diagnostic Radiology Services (continued)

- Restrictions
  - Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities. You may also call us for information about any restrictions.
  - Select radiology procedures, such as CAT, MRI and PET scans are payable **if**:
    - The provider requests preapproval
    - The procedures for which preapproval was requested fall within BCBSM medical policy guidelines
    - The procedures are performed in a participating facility. You or your physician may call us about the status of a specific facility.
    - We approve the procedures

    If any of these requirements are not met, BCBSM will **not** pay for the procedure. You will not be responsible for paying the provider for a procedure that has not been preapproved.

- Preapproval is not required for radiology procedures that are:
  - Performed out-of-state
  - Performed in cases of emergency

You may call us for information about any restrictions.

**We do not pay for:**

Procedures that are not related and needed to diagnose a disease, illness, injury or pregnancy (such as an ultrasound done only to find out the sex of a fetus).

Therapeutic Radiology Services

We pay for physician's services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. This benefit covers the outpatient treatment of breast cancer. The services must be provided by your physician or, by another physician if agreed on by your physician.

## *Skilled Nursing Facility Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

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

Requirements:

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

- The skilled nursing facility **participates** with BCBSM
- The admission is ordered by the patient's attending physician
- The admission has been pre-approved by BCBSM

We need written confirmation from your physician that **skilled care** is needed.

Length of Stay

We pay only for the period that is necessary for the proper care and treatment of the patient. The maximum length of stay is 45 days per member, per calendar year.

**We pay for:**

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or purchased from the skilled nursing facility
- Physician services (up to two visits per week)
- Physical therapy (Page 69), speech and language pathology services (Page 103) or occupational therapy (Page 56) when medically necessary

The physical and occupational therapy or speech-language pathology services that are done in a skilled nursing facility are inpatient benefits. The 30-visit benefit maximum applies only when these services are provided on an outpatient basis.

**Skilled Nursing Facility Services** (continued)

**We do not pay for:**

- Custodial care
- Care for senility or developmental disability
- Care for substance abuse
- Care for mental illness
- Care provided by a nonparticipating skilled nursing facility

## *Special Medical Foods for Inborn Errors of Metabolism*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

**We pay for:**

Special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by a physician after he or she has done a complete medical evaluation of the patient's condition.

The following criteria must be met:

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

**NOTE:** BCBSM determines which conditions are payable

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

Blue Cross Blue Shield of Michigan
Regular Claims, Special Programs, Mail Code 608A
600 E. Lafayette Blvd
Detroit, MI 48226

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

**We do not pay for:**

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

  NOTE

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

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

## *Speech and Language Pathology*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For occupational therapy services, see Page 56.
For physical therapy services, see Page 69.
Special rules apply when speech and language pathology services are provided to treat autism (see Page 23).

Locations: We pay for facility and professional speech and language pathology services in the following locations:

- A participating hospital, inpatient or outpatient

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

- A participating freestanding outpatient physical therapy facility

  NOTE We pay freestanding facilities for physical therapy services. We do not pay the person who provided the services.

- A professional provider's office

- A participating skilled nursing facility

- The patient's home (see Page 101for when services may be payable in a nursing home.)

**We pay for:**

- Medically necessary speech and language pathology services when you are an inpatient in a hospital or skilled nursing facility subject to conditions described further down in this section

- A maximum of 30 outpatient visits per member per calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home)

  NOTE This visit maximum is separate from any physical or occupational therapy you may get.

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

**Speech and Language Pathology** (continued)

**We pay for:** (continued)

Speech and language pathology services must be:

- Prescribed by a physician (M.D. or D.O.) or a dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
- Given by:
  - A speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

NOTE

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

**We do not pay for:**

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE

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

- Recreational therapy
- Patient education and home programs
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

NOTE

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

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a treatment plan that guides and helps to monitor the provided therapy

**Speech and Language Pathology** (continued)

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

- Services provided by speech-language pathology assistants or therapy aides
- Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility
- More than 30 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider
- Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Services received from other facilities independent of a hospital

## *Substance Abuse Treatment Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For mental health services, please see Page 52.

For emergency services to treat substance abuse conditions, please see Page 39.

Locations: We will pay for substance abuse treatment services in:

- An inpatient hospital
- An outpatient hospital
- A residential or outpatient treatment program

All services are subject to the conditions described below.

NOTE

Substance abuse services are subject to deductible, copayment and coinsurance – please see Section 2.

**Inpatient Substance Abuse Treatment Services**

- **We pay for** treatment of substance abuse in a participating hospital when approved by BCBSM.

**Outpatient and Residential Substance Abuse Treatment Services**

- We pay for substance abuse treatment in a:
  - Residential or
  - Participating outpatient treatment center.

  The following criteria must be met.

  - Your attending physician must find that you need substance abuse treatment and state if the treatment should be residential or outpatient.
  - Your attending physician must:
    - Provide an initial physical exam
    - Diagnose the patient with a substance abuse condition
    - Certify that the required treatment can be given in a residential or an outpatient center
    - Provide and supervise your care during detoxification and
    - Provide follow-up care during rehabilitation
  - The services need to be medically necessary to treat your condition.
  - The services must be approved by BCBSM. They must also be provided by a participating substance abuse treatment program.

- **We pay for the following services provided and billed by an approved program:**

  - Lab exams
  - Diagnostic exams
  - Supplies and equipment used for detoxification or rehabilitation
  - Professional and trained staff services and program services necessary for care and treatment
  - Individual and group therapy or counseling
  - Counseling for family members
  - Psychological testing

- **We also pay for** the following in a residential substance abuse treatment program:

  - Bed and board
  - General nursing services
  - Drugs, biologicals and solutions used in the facility
  - The assistance of a consulting physician when you are in a participating residential substance abuse treatment program if the physician in charge of your case requests the assistance because special skill or knowledge is required to diagnose or treat the condition.

- **We also pay for** the following in an outpatient substance abuse treatment program:

  - Drugs, biologicals and solutions used in the program, including drugs taken home

**We do not pay for:**

- Services provided by a nonparticipating hospital, inpatient, residential, or outpatient facility

- Services provided primarily for the treatment of a diagnosis other than substance abuse

- Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program

- Diversional therapy

- Services provided beyond the period necessary for care and treatment

- Staff consultations required by a facility or program's rules.

## *Surgery*

*See Section 2 beginning on Page 10 for what you may need to pay for these services.*

For transplant services, see Page 117.

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

- A participating hospital, as an inpatient or an outpatient
- A participating freestanding ambulatory surgery facility
- A professional provider's or physician's office

**We pay for:**

**Presurgical Consultations**

If your physician tells you that you need surgery, you may choose to have a presurgical consultation with another physician. The consulting physician must be an MD, DO, podiatrist or an oral surgeon. The physician must also be an in-network provider.

- The consultation will be paid for if the surgery you plan to have is covered under this certificate and will be done in a hospital (as an inpatient or an outpatient) or in an ambulatory surgery center.
- You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:
  - Second opinion — a consultation to confirm the need for surgery
  - Third opinion — allowed if the second opinion differs from the initial proposal for surgery
  - Nonsurgical opinion — given to determine your medical tolerance for the proposed surgery

**Presurgical consultations obtained from an out-of-network provider are not covered.**

**Surgery**

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the patient is in the hospital
- Visits to the attending physician for the usual care before and after surgery
- Operating room services, including delivery and surgical treatment rooms
- Bariatric surgery

NOTE Bariatric surgery is limited to one per member per lifetime

**Surgery** (continued)

**We pay for**: (continued)

- Sleep studies and surgeries to diagnose and treat sleep apnea

  NOTE Sleep studies and surgeries must be preapproved by BCBSM.

- Sterilization (whether or not medically necessary), including for males in a physician's office or other approved location

  NOTE As part of your preventive services, we cover voluntary sterilization for females (see Page 91).

  NOTE Reversal of voluntary sterilization for males is not covered.

- Administration of blood

- **Cosmetic surgery** is only payable for:

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

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

**We do not pay for:**

- Gender reassignment surgery, reversal of prior gender reassignment surgery or any other surgical procedures related to Gender Identify Disorder, including, but not limited to surgical procedures involving the face, vocal cords, breasts, abdomen, or hips.

**Surgery** (continued)

**We pay for:**

- **Dental Surgery**: Dental surgery is **only** payable for:
  - Multiple extractions or removal of unerupted teeth or alveoplasty when:
    - A hospitalized patient has a dental condition that is adversely affecting a medical condition, and
    - Treatment of the dental condition is expected to improve the medical condition (see Page 30 for examples)
  - Surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ), see Page 32.
- **Multiple surgeries** performed on the same day by the same physician are payable according to national standards recognized by BCBSM.
- Medically necessary **Plastic Surgery,** limited to:
  - Blepharoplasty of Upper Lids
  - Breast Reduction
  - Surgical Treatment of Male Gynecomastia
- Sleep Apnea Treatments:
  - Panniculectomy
  - Rhinoplasty
  - Septorhinoplasty
- **Technical surgical assistance (TSA**): In some cases, a surgeon will need another physician to give them technical assistance. We pay the approved amount for TSA, according to our guidelines. The surgery can be done in a:
  - Hospital (inpatient or outpatient)
  - Ambulatory surgery facility
  -
  - Contact customer service for a list of covered TSA surgeries.

  We do **not** pay for TSA:

  - When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
  - When services are provided in a location other than a hospital or ambulatory surgery facility

**Surgery** (continued)

**We pay for**: (continued)

**Freestanding Ambulatory Surgery Facility Services**

We pay for facility services in a BCBSM **participating** ambulatory surgery center. The services must be medically necessary. You must be a patient of a licensed MD, DO, podiatrist or oral surgeon to be admitted to the center. The services must be directly related to the covered surgery.

**We pay for:**

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

**We do not pay for:**

- Services by a nonparticipating ambulatory surgery facility
- Gender reassignment surgery, reversal of prior gender reassignment surgery or any other surgical procedures related to Gender Identify Disorder, including, but not limited to surgical procedures involving the face, vocal cords, breasts, abdomen, or hips.

## *Temporary Benefits for Out-of-network Hospital Services*

The following rules will apply when a participating hospital terminates its contract with BCBSM.

We pay temporary benefits for some services of noncontracted hospitals. These benefits are for designated services, emergency care, and travel and lodging. These benefits are available for **six months** from the date the hospital terminates its participating contract with BCBSM. (Also see "Section 3: What We Pay For.")

Mandatory Preapproval

You must get preapproval from BCBSM before the services described in this certificate (except emergency care or ambulance services) will be paid. If you do not get preapproval for the services, you will have to pay for them.

Our customer service representatives can provide you and your physician with the telephone number to call for preapproval (see Section 9 "How to Reach Us"). If your request for preapproval is for a bone marrow or organ transplant, ask your customer service representative for the telephone number of the Human Organ Transplant Program. For more information on transplants, see Page 117.

When we preapprove your services we do not guarantee that the claims for those services will be paid. All claims are subject to a review of the reported diagnosis and verification that the services were medically necessary. We will verify that the benefits were available when the claim is processed. We also check the following before paying a claim:

- The requirements and conditions under your BCBSM certificate
- Your certificate's limitations and exclusions
- Your benefit maximums, deductibles, coinsurance and copayments

**Preapproval must be obtained as follows:**

- **Designated Services**

  Your physician must obtain preapproval for designated services by calling BCBSM. If your physician does not get the preapproval, the designated services you receive will not be covered and you will have to pay for the hospital's charges.

- **Travel and Lodging**

  You must obtain preapproval for any travel and lodging expenses before they occur. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs. Please call BCBSM to obtain preapproval.

**Temporary Benefits for Out-of-network Hospital Services** (continued)

**Payable Services**

- **Designated Services and Emergency Care**

  Coverage Requirements

  We will pay for designated services and emergency care that you receive from a hospital that is not contracted with BCBSM (also known as a noncontracting hospital) when all of the following criteria are met:

  - The services are medically necessary and would be covered if the noncontracted area hospital was a BCBSM in-network or participating hospital
  - The designated services are preapproved, as previously described
  - The noncontracted area hospital is within 75 miles of your primary residence (this applies only to designated services)

  Payment for Designated Services and Emergency Care

  When the above coverage requirements are met, we will pay you as follows:

  - Designated Services

    We will pay our approved amount, less any deductibles, coinsurance and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.

  - Emergency Care

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

    We pay the greater of the:

    - Median in-network rate we pay for the accidental injury or emergency service
    - Rate we would pay a nonparticipating, out-of-network hospital for the accidental injury or emergency service. This rate is calculated using the method we generally use to set rates for these services from these types of providers.
    - Medicare rate to treat the accidental injury or emergency service.

    These rates are calculated according to the requirements of the Patient Protection and Affordable Care Act.

    The rate we pay may be less than the hospital's bill. You will be required to pay the difference.

You will not have to pay any out-of-network cost-sharing that apply to these services. However, you must pay any in-network cost-sharing that apply. In some cases, cost-sharing may be waived. See page 16for information about what cost-sharing you must pay for accidental injuries and emergency services.

**Payable Services** (continued)

**Designated Services and Emergency Care** (continued)

Transport from a Noncontracted Area Hospital

If you are receiving designated services or emergency care in a hospital that is not contracted with BCBSM, and your physician says that you are medically stable, you may choose to be transferred to the nearest participating hospital that can treat your condition. We will pay our approved amount to transport you by ambulance to that hospital.

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

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

BCBSM certificates will provide only limited coverage for emergency services at nonparticipating hospitals. They provide you with no coverage if you are admitted on a nonemergency basis. If you decide to stay in a noncontracted hospital, we will pay you at the nonparticipating rate. Our rate may be less than the hospital charges. You will have to pay the difference.

Limitations and Exclusions

- If you get services from a noncontracted hospital that are not designated services, we will pay only the amount we pay for nonparticipating hospital services. These amounts are described in Section 2. You will have to pay the difference between what we pay and the hospital's charge. This difference may be substantial since we do not pay for nonemergency services in a nonparticipating hospital.
- We do not pay for designated services that were not preapproved, as previously described.
- We will pay for ambulance transport services only if they are for an admission that is covered under this certificate. If your certificate covers nonemergency transports, you will have to pay for any deductibles and coinsurance.

- **Travel and Lodging**

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

- You live within 75 miles of the noncontracted area hospital
- You cannot reasonably get covered services from:

  - A contracted hospital in your area or other participating provider within 75 miles of the noncontracted area hospital, and
  - Your physician directs you to an out-of-area hospital.
  - You get services from the out-of-area BCBSM in-network or participating hospital that is closest to the noncontracted area hospital

**Travel and Lodging** (continued)

**Payment will be subject to the following provisions:**

Inpatient Services

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

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

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

Outpatient Services

If you need outpatient services from an out-of-area hospital or physician, we will pay up to $125 for travel and lodging each time you need these services. Physician services must be directly related to your admission to an out-of-area hospital.

Limitations and Exclusions

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

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

- The deductibles, copayments or coinsurances that you pay for other services, you will not have to pay for travel and lodging.

Remember, your temporary benefits will end **six months** from the date a noncontracted hospital ends its participating contract with BCBSM.

## *Transplant Services*

*See Section 2 beginning on Page 10 for what you may be required to pay for these services.*

For general surgery services, see Page 109.

For oncology clinical trials, see Page 60.

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

- **Participating** hospital (inpatient or outpatient)
- **Participating** ambulatory surgery facility

We cover transplants of specified organs such as heart or liver (complete list on Page 121) **only** if they are done in a "designated facility" and only when you obtain BCBSM prior approval. (See the definition of a designated facility on Page 160.)

**We pay for:**

**Organ transplants**

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

- Kidney
- Cornea
- Skin
- Bone marrow (described below)

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

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

We will pay covered services for donors if the donor does not have transplant benefits under any health care plan.

**Transplant Services** (continued)

**We pay for:** (continued)

Bone Marrow Transplants

We pay for the services listed below, for each member and for each condition, when they are directly related to one of the following conditions:

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

We cover the donor's harvesting and storage if it is not covered by their insurance, but only when the recipient is a BCBSM member. In a case of sickle cell anemia (ss or sc) or beta thalassemia, the donor must be an HLA-identical sibling.

  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
  - T-cell depleted infusion
  - Donor lymphocyte infusion
  - Hospitalization

**Transplant Services** (continued)

Bone Marrow Transplants (continued)

**We pay for:** (continued)

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

A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. See the definition of "Tandem Transplant" in Section 7.

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

- **Autologous transplants are covered to treat only certain conditions. Please call Customer Service for a list of these conditions.**

**Additional services for bone marrow transplants:**

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

- High-dose chemotherapy

- Total body irradiation

- Allogeneic or autologous transplants to treat conditions that are not experimental

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

**We do not pay the following for bone marrow transplants:**

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

**Transplant Services** (continued)

**Specified Human Organ Transplants**

When performed in a designated facility (see Section 7 “Definitions” on Page 160), **we pay for** transplant of the following organs:

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

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

All specified human organ transplant services must be provided during the benefit period if they are going to be paid by BCBSM. It begins five days before the transplant and ends one year after the transplant. The only exceptions are anti-rejection drugs and other transplant-related prescription drugs.

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

When directly related to the transplant, we pay for:

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

NOTE

We will pay for any service that you need to treat a condition that is a direct result of an organ transplant surgery. The condition must be a benefit under one of our certificates.

**We also pay for** the following:

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

NOTE

In some cases, we may pay for return travel to the original transplant facility if you have an acute rejection episode. The episode must be emergent and must fall within the benefit period. The cost of the travel must still fall under the $10,000 maximum for travel and lodging.

  - Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)
  - Cost of acquiring the organ (the organ recipient must be a BCBSM member.) This includes, but is not limited to:
    - Surgery to obtain the organ
    - Storage of the organ
    - Transportation of the organ
    - Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
    - Payment for covered services for a donor if the donor does not have transplant services under any health care plan

NOTE

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

**Transplant Services** (continued)

**Specified Human Organ Transplants** (continued)

Limitations and Exclusions

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

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

  NOTE

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

- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:
  - Mortgage or rent payments
  - Furniture rental
  - Dry cleaning or laundry services
  - Clothing, toiletries
  - Kennel fees
  - Car maintenance
  - Security deposits, cash advances
  - Lost wages
  - Tips
  - Household products
  - Alcoholic beverages
  - Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services
  - Household utilities (including cellular telephones)
  - Maids, babysitters or day care services
  - Services provided by family members
  - Reimbursement of food stamps
  - Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)
- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate
- Experimental transplant procedures. See the “General Conditions of Your Contract” section for guidelines related to experimental treatment.

## *Urgent Care Services*

*See Page 16 in Section 2 for what you may be required to pay for these services.*

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

# Section 4: How Providers Are Paid

This section explains how BCBSM pays its providers, who are the people or facilities that provide services or supplies related to your medical care. They include, but are not limited to, hospitals, physicians, licensed clinics, labs, and health care professionals. Our PPO payment policy is shown in the chart below.

| | |
|---|---|
| **PPO In-network Providers** | BCBSM sends payment directly to in-network providers. They accept this payment, which is our approved amount, as payment in full for covered services.<br><br>In-network PPO providers have an agreement with BCBSM to provide services through the BCBSM PPO program. They have agreed to accept BCBSM's approved amount as payment in full for the covered services they provide. BCBSM sends payment for the approved amount directly to the in-network providers. |
| **PPO Out-of-Network Providers** | Out-of-network providers do *not* have an agreement with BCBSM to provide their services through the BCBSM PPO program.<br><br>If you do not have a referral from an in-network provider, and you get services from an out-of-network provider, BCBSM will deem those services as out-of-network. Not all services are covered out-of-network.<br><br>Before you make an appointment with an out-of-network provider, you will need to find out if they are a participating or a nonparticipating provider with BCBSM.<br><br>*Here's why:*<br><br>• **Participating providers** — BCBSM will send the payment directly to the participating providers. They will accept the payment of BCBSM's approved amount as payment in full.<br><br>• **Nonparticipating physicians and other professional providers** — BCBSM will send the payment directly to you. You will need to pay the physician.<br><br>• **Nonparticipating hospitals, facilities and alternative to hospital care providers*** — BCBSM will not pay for medical services from nonparticipating hospitals unless it is for the treatment of accidental injuries or medical emergencies. Otherwise, you will need to pay most of those charges yourself. |

* Home health care, home infusion therapy, hospice care, and care in a skilled nursing facility are some of the alternatives to a hospital.

BCBSM has business contracts with different types of providers. Each type of provider has separate payment practices. In this section we will describe the payment practices that we have with the following types of providers:

- PPO In-network Providers
- PPO Out-of-Network Providers
- BlueCard® PPO Program
- Negotiated (non-BlueCard Program) Arrangements
- BlueCard® Worldwide Program

## *PPO In-Network Providers*

When you receive services from an in-network provider, we will pay our approved amount for covered services directly to your provider. You are responsible to pay for only the:

- Deductible
- Copayments
- Coinsurances

These services are explained in Section 2 "What You Must Pay" of this certificate.

### In-Network Providers

| Provider Status | Type of Provider | COVERED SERVICES | | | |
|---|---|---|---|---|---|
| | | BCBSM Pays | | You Pay | |
| | | Amount | Whom | Amount | Whom |
| PPO In-Network | Professionals, Hospitals and Facilities | BCBSM's approved amount minus what you must pay | Provider* | In-Network<br>• Deductible<br>• Coinsurance<br>• Copayments<br>(See Section 2) | Provider |
| | | NON-COVERED SERVICES | | | |
| | | You may be billed for: | | You may NOT be billed for: | |
| | | • Services not covered by your contract.<br>• Services that BCBSM has determined are not medically necessary or are experimental<br>You may be billed only if:<br>– You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary, or it is experimental and you agree to pay for the service<br>– The provider gives you an estimate of what the services will cost you<br>• If you do not provide the required identifying information in a timely manner so the provider can file a claim** | | • Services that are not covered because BCBSM determined that the provider did not have the required credentials or privileges to perform the services, or the provider did not comply with BCBSM policies when providing the services<br>• An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM*<br>• Balances that are more than the approved amounts | |

*If you need to know what providers are paid directly, call customer service. See Section 9: "How to Reach Us."

** BCBSM may deny a claim from a participating provider that was sent in more than:

- 180 days (for professional claims)
- 12 months (for facility claims)
- 15 months (for home infusion therapy claims)
- or after the service because you did not furnish needed information.

## *PPO Out-of-Network Providers*

When you receive covered services from an out-of-network provider, the amount that BCBSM will pay that provider and the amount you will need to pay, will depend on whether the provider does or does not participate in a BCBSM PPO program.

**Out-of-Network Participating Providers**

| Provider Status | Type of Provider | COVERED SERVICES | | | |
|---|---|---|---|---|---|
| | | BCBSM Pays | | You Pay | |
| | | Amount | Whom | Amount | Whom |
| **Out-of-Network Participating Provider** | **Professionals, Hospitals and Facilities** | BCBSM's approved amount minus what you must pay | Provider | Out-of-Network<br>• Deductible<br>• Coinsurance<br>• Copayments<br>(see Section 2)<br><br>Out-of-network deductibles, coinsurances and copayments are not applied to:<br>• Services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office<br>• Services from a provider for which there is no PPO network<br>• Services from an out-of-network provider in an area of Michigan that BCBSM has deemed a "low-access area" for that provider specialty | Provider |

When you receive covered services from an out-of-network provider, you will be required to pay a coinsurance and copayment for most covered services after your out-of-network deductible requirement has been paid (see Section 2), unless you were referred to that provider by a PPO in-network provider. (You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network deductible, coinsurance and copayment requirements)

You may not need to pay your out-of-network deductible, copayment, or coinsurance if:

- The service was performed by an out-of-network provider in:
  - An in-network hospital
  - A participating freestanding ambulatory surgery facility or
  - Any other location identified by BCBSM

  You may contact BCBSM for information about these services.

**PPO Out-of-Network Providers** (continued)

- Your screening mammography is read and interpreted by an in-network provider but an out-of-network provider does the analysis and interprets the results

You may not have to pay for the out-of-network deductible, copayment and coinsurance when you get medical services. But you *will* have to pay for the in-network deductible, copayment and coinsurance.

If you need to know when you will not have to pay your out-of-network cost-share, call us at one of the numbers listed in Section 9: "How to Reach Us".

If you receive services from an out-of-network provider, the amount you pay will depend on the provider's status. BCBSM pays more to participating providers than to nonparticipating providers. The more BCBSM pays, the less you pay.

**When Out-of-Network Participating Providers May or May Not Bill You**

| Provider Status | Type of Provider | NON-COVERED SERVICES | |
|---|---|---|---|
| | | **You may be billed for:** | **You may NOT be billed for:** |
| **Out-of-Network Participating Provider** | **Professionals Hospitals and Facilities** | • Services not covered by your contract<br>• Services that BCBSM has determined are not medically necessary or are experimental.<br>You may be billed only if:<br>– You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary or it is experimental and you agree to pay for the service<br>– The provider gives you an estimate of what the services will cost you<br>• If you do not provide the required identifying information in a timely manner so the provider can file a claim. * | • Services that are not covered because BCBSM determined that the provider did not have the required credentials or privileges to perform the services, or the provider did not comply with BCBSM policies when providing the services<br>• An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM<br>• A balance in excess of our approved amount |

**When Out-of-Network Participating Providers May or May Not Bill You** (continued)

** BCBSM may deny a claim from a participating provider that was sent in more than:

- 180 days (for professional claims)
- 12 months (for facility claims)
- 15 months (for home infusion therapy claims)
- or after the service because you did not furnish needed information.

**Out-of-Network Nonparticipating Providers**

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

If we approve the claim, we will send the payment to you.

| Provider Status | Type of Provider | COVERED SERVICES | | | |
|---|---|---|---|---|---|
| | | BCBSM Pays | | You Pay | |
| | | Amount | Whom | Amount | Whom |
| Out-of-Network Nonparticipating Provider* | Professional | BCBSM's approved amount minus what you must pay | Member | Out-of-Network<br>• Deductible<br>• Coinsurance<br>• Copayments<br>AND<br>The difference between BCBSM's approved amount and the amount charged by the nonparticipating provider | Provider |
| | Hospital and Facilities | • BCBSM coverage is limited to treatment of an accidental injury or medical emergency<br>For these services, BCBSM's payment is limited (see Page 116) | Member | In-Network<br>• Deductible<br>• Coinsurance<br>• Copayments<br>AND<br>The difference between BCBSM's payment and the amount charged by the nonparticipating provider | Provider |

**Out-of-Network Nonparticipating Providers** (continued)

To receive payment for covered services provided by a nonparticipating provider, you will need to send us a claim. Call your customer service representative (see Section 9: "How to Reach Us") for information on filing claims.

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

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

- Independent physical therapists
- Certified nurse practitioners
- Independent occupational therapists
- Independent speech-language pathologists
- Audiologists

**BCBSM does not pay for services at nonparticipating:**

- **Substance abuse treatment facilities**
- **Freestanding ambulatory surgery facilities**
- **Freestanding ESRD facilities**
- **Home health care agencies**
- **Hospice program providers**
- **Home infusion therapy providers**
- **Ambulatory infusion centers**
- **Long-term Acute Care Hospitals**

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

## *BlueCard® PPO Program*

We participate with other Blue Cross and/or Blue Shield Plans in the BlueCard PPO Program. This program offers medical benefits to Blue Cross and/or Blue Shield members when they are out of their local service area, such as out of state. The Blue Cross and/or Blue Shield Plan that provides those covered services to you is your Host Plan. BCBSM will pay the Host Plan for the covered services that they provided to you. However, the Host Plan is responsible for contracting with its participating providers and making sure they receive payment.

**BlueCard PPO In-Network Providers**

If you receive covered services from an out-of-area PPO network provider:

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

Network status is not based on provider participation with BCBSM. It is based on participation with the Plan where the services were provided.

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

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

Often this “negotiated price” will be a discounted price that is the actual price the Host Plan pays your provider. Sometimes it includes special arrangements with your provider or provider group. The special arrangements may include settlements, incentive payments, and other credits or charges. At other times the negotiated price may be the average price of the same kind of service performed by similar types of providers.

Estimated and average pricing also include adjustments we may need to make to estimates of past pricing for transaction changes noted above. These adjustments will not affect the price we pay for your claim because they are not applied to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If you receive services in a state that imposes such a fee, we will calculate what you need to pay according to the applicable laws of that state.

## BlueCard PPO Out-of-Network Providers

If the provider is not a PPO network provider, we will notify the Host Plan to reduce its payment to the amount specified under this certificate for services provided by an out-of-network provider, unless:

- You were referred to that provider by a PPO network provider. (You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network deductible, copayment and coinsurance requirements) or
- You needed care for an accidental injury or a medical emergency (see Emergency Services in Section 7 “Definitions”).

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider’s status.

## Nonparticipating Providers Outside Our Service Area

An out-of-area provider that does not participate with BCBSM or the local Host Plan may require you to pay for services at the time they are provided. If they do:

- Call your customer service representative at one of the numbers listed in Section 9: “How to Reach Us” for information on filing claims.
- Submit an itemized statement to us for the services.
- We will pay you the amount stated in this certificate for covered services provided by a nonparticipating provider. We do not pay for services of the nonparticipating facility providers listed on Page 123. We provide very limited coverage for the services of nonparticipating hospitals.

**In all cases, you are responsible for the out-of-network deductible, copayment and/or coinsurance payments that are covered in this certificate.**

To find out if an out of area provider is a BlueCard or BCBSM PPO provider, please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com to see a list of participating providers.

## Member Liability Calculation

When you receive covered services outside of our service area from nonparticipating providers, the amount you pay for these services will generally be based on either:

- What the Host Plan pays its nonparticipating providers or
- The price required by applicable state law

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount that BCBSM paid for the service.

**Member Liability Calculation** (continued)

Exceptions:

In some situations, we may use other payment methods to determine the amount we will pay for services rendered by nonparticipating providers.

These methods may include:

- Billed covered charges
- The payment we would make if the services were provided in our service area
- A special negotiated payment

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount we will pay for the covered services.

**Specialty Providers in the BlueCard Program**

The Host Plan can pay for you to get medical care from providers who offer special services (e.g., Allergist, Chiropractor, Podiatrist) within the Host Plan's area, even if the provider offers a specialty that BCBSM does not cover. As long as the Host Plan contracts with the specialty provider, the services they provide to you will be paid.

**BlueCard PPO Program Exceptions**

The BlueCard PPO Program will not apply if:

- The services are not a benefit under this certificate.
- The provider specialty is not covered by BCBSM or the Host Plan.
- This certificate excludes coverage for services performed outside of Michigan.
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program.
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program, or
- The services are performed by a vendor or provider who does not have a contract with BCBSM for those services.

## *Negotiated (non-BlueCard Program) Arrangements*

As an alternative to the BlueCard Program, we may process your claims for covered services through an arrangement that we have negotiated with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the:

- Negotiated price or
- Lower of either the billed charges or the negotiated price that the Host Plan has made available to us.

## *BlueCard® Worldwide Program*

If you are living or traveling outside of the United States, the BlueCard Worldwide Program will assist you in getting covered health care services. This program provides access to a worldwide network of inpatient, outpatient and professional providers and it also includes claims support services.

The BlueCard Worldwide Program is different from the BlueCard PPO Program in certain ways. For example, although the BlueCard Worldwide Program assists you with accessing a network of health care providers, the network does not have Host Plans.

A PPO network is not available outside the United States.

In this section, references to participating or nonparticipating providers mean they participate or do not participate in the BlueCard Worldwide Program.

**Medical Assistance Services**

If you need medical services while traveling or living outside of the United States, contact the BlueCard Worldwide Service Center at:

- 1-800-810-BLUE (2583) or
- Call 804-673-1177 collect, if you are calling from outside the United States

They will help you get the information about participating hospitals, physicians and medical assistance services. If you do not contact the BlueCard Worldwide Service Center, you may have to pay for all of the services that you receive.

**Coverage for BlueCard Worldwide Participating Hospitals**

**Inpatient Hospital Services**

- If you need to be admitted to a hospital as an inpatient, call the BlueCard Worldwide Service Center to arrange for cashless access with a participating hospital. Cashless access means that you will only have to pay the in-network deductible(s) coinsurance(s) and copayment(s) for all covered services when you are admitted to the hospital. The hospital will file the claim with the BlueCard Worldwide Service Center for you.

You are responsible for:

- In-network deductible(s), copayment(s) and coinsurances
- The payment of noncovered services
- If you do not contact the BlueCard Worldwide Service Center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive.
- Submitting the international claim form(s), if you did not get cashless access
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.



**Outpatient Hospital Services**

You are responsible for:

- Paying for all of the outpatient services at the time they are provided
- Submitting the international claim form(s)
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**BlueCard Worldwide Program** (continued)

**Coverage for BlueCard Worldwide Nonparticipating Hospitals**

**Inpatient Hospital Services**

- If you need to be admitted to a nonparticipating hospital as an inpatient, call the BlueCard Worldwide Service Center to get a referral for cashless access. Cashless access means that you will only have to pay the out-of-network deductible(s) coinsurance(s) and copayment(s) for all covered services you receive when you are admitted to the hospital. The hospital will file the claim with the BlueCard Worldwide Service Center for you.

You are responsible for:

- Out-of-network deductible(s), copayment(s) and coinsurances
- The payment of noncovered services
- If you set up cashless access, you will be responsible for the out-of-network deductible(s) coinsurance(s) and copayment(s) and non-covered services.
- If you do not contact the BlueCard Worldwide Service Center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive.
- Submitting the international claim form(s), if you did not get cashless access
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.
  -
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.

**Outpatient Hospital Services**

You are responsible for:

- Paying for all outpatient services at the time they are provided
- Submitting the international claim form(s)
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**BlueCard Worldwide Program** (continued)

**Emergency Services at Participating or Nonparticipating Hospitals**

- In the case of an emergency, you should go to the nearest hospital. If you are admitted, follow the process for inpatient hospital services.
- If you are not admitted to the hospital, you must pay for all professional and outpatient services at the time they are provided.
- You are responsible for submitting the international claim form(s).
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.
- You must provide copies of your medical record, the itemized bill, and proof of payment along with the claim form. BCBSM will only pay for covered services.

**BlueCard Worldwide Professional Services**

- You are responsible for payment of all professional services at the time they are provided.
- You are also responsible for submitting the international claim form(s).
  - Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com.
- You must provide copies of your medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

# Section 5: General Services We Do Not Pay For

The services listed in this section are in addition to all other **nonpayable** services stated in this certificate.

**We do not pay for:**

- Noncontractual services that are described in your case management treatment plan, if the services have not been approved by BCBSM.

- Services performed by out-of-state providers that are not registered with their local Blue Cross/ Blue Shield plan

- Services for gender reassignment such as hospital admissions, facility and professional services, including hormonal therapy

- Services to treat Gender Identity Disorder, such as:

  - Hospital admissions
  - Facility and professional services
  - Office visits, including those for behavioral health or substance abuse therapy
  - Hormonal therapy, which includes drugs, injection of the drugs and other services to administer the drugs

- Services for an elective abortion such as hospital admissions, facility and professional services and including services, care, supplies or devices related to an elective abortion. We do not pay for services, devices, drugs or other substances prescribed by any provider to terminate a woman's pregnancy for any purpose other than to:

  - Increase the probability of a live birth
  - Preserve the life or health of the child after a live birth
  - Remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman

  NOTE

  Elective abortions do not include:

    – A prescription drug or device intended as a contraceptive
    – Services, devices, drugs or other substances provided by a physician to terminate a pregnancy because the physician believes the woman's physical condition requires that her pregnancy be terminated to avoid her death.
    – Treatment of a woman experiencing a miscarriage or who has been diagnosed with an ectopic pregnancy.

  - Artificial insemination

**We Do Not Pay For:** (continued)

- Services that are not acute, such as:

  - Observation
  - Diagnostic evaluations
  - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
  - Lab exams
  - Electrocardiography
  - X-ray, exams or therapy
  - Cobalt or ultrasound studies
  - Basal metabolism tests
  - Convalescence, rest care or convenience items
  - Cosmetic surgery primarily to improve appearance

- Those mainly for physical therapy, speech and language pathology services or occupational therapy

- Reversible or irreversible treatment of temporomandibular joint (jaw joint) disorder except for surgery directly on the jaw joint

- Hospital services that we do not pay for:

  - Artificial insemination
  - Services that may be medically necessary but can be provided safely in an outpatient or office location
  - Custodial care or rest therapy
  - Private duty nursing services
  - Outpatient rehabilitation services that require less than intensive monitoring or supervision (EKGs) because the patient's endurance while exercising and management of risk factors are stable
  - Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
  - Outpatient inhalation therapy
  - Sports medicine, patient education or home exercise programs
  - Services, care, supplies or devices related to an elective abortion (see above for more information about this exclusion)

- **Facility services that we do not pay for:**

  - Services, care, supplies or devices related to an elective abortion (see above for more information about this exclusion)
  - Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution

If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

**We Do Not Pay For:** (continued)

- **Professional provider services that we do not pay for:**

  - Services for artificial insemination
  - Services, care, supplies or devices not prescribed by a physician
  - Services, care, supplies or devices related to an elective abortion (see above for more information about this exclusion)
  - Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
  - Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on Page 110
  - Services provided during nonemergency medical transport
  - Experimental treatment
  - Annual, pre-employment, pre-marital, school, sports, and routine examinations or physicals unless needed to diagnose or treat a specific disease, illness, pregnancy, or injury
  - Care received at a medical clinic provided or maintained by an employer
  - Hearing aids or services to examine, prepare, fit or obtain hearing aids
  - Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged or providers who are not legally authorized or licensed to order or provide such services.

If a participating BCBSM PPO in-network provider has not been credentialed or privileged by BCBSM to perform a service, they will be financially responsible for the entire cost of the service. They cannot bill you for their services. They also cannot bill you for any deductibles, copayments, or coinsurance amounts.

If you decide to get medical services from a nonparticipating out-of-network provider, who is not credentialed or privileged to perform those services, you will have to pay for the entire cost of the service.

  - Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
  - Benefits for eye surgeries such as, but not limited to, LASIK, and PRK, or RK performed to correct visual acuity
  - Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
  - Sports medicine, patient education (except as otherwise specified) or home exercise programs
  - Screening services (except as otherwise stated)
  - Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

- Nutritional products, supplements, medical foods, infant formulas or low-protein modified foods for medical conditions or inherited diseases of childhood

- Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs

# Section 6: General Conditions of Your Contract

**This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.**

## *Assignment*

Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. Also, you cannot assign your right to payment from us, claim or cause of action against us to a provider. We will not pay a provider except under the terms of this certificate.

## *Changes in Your Family*

You must notify us of any changes in your family. This requires you to complete and submit an enrollment/change of status form (you may fax or mail the form). Any coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service. An enrollment/change of status form should be completed when you have a change of address.

## *Changes to Your Certificate*

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

## *Claim Forms*

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

## *Coordination of Benefits*

We coordinate benefits payable under this certificate per Michigan's Coordination of Benefits Act.

## *Coverage for Drugs and Devices*

We do not pay for a drug or device prescribed for uses or in dosages other than those approved by the Federal Food and Drug Administration. (This is called the off-label use of a drug or device.) However, we will pay for them and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. proves that the drug or device is recognized for treatment of the condition it is prescribed for by:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE Chemotherapeutic drugs are not subject to this general condition.

## *Deductibles, Copayments and Coinsurances Paid Under Other Certificates*

We do not pay any cost-sharing you must pay under any other certificate. An exception is when we must pay them under coordination of benefits requirements.

## *Entire Contract; Changes*

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

## *Experimental Treatment*

Services That Are Not Payable

We do not pay for:

- Experimental treatment. This includes experimental drugs and devices
- Services related to experimental treatment
- Administrative costs related to the above
- Costs of research management.

NOTE See "Clinical Trials (Routine Patient Costs), "Oncology Clinical Trials" in Section 3 and "Services That Are Payable" below for exceptions.

NOTE This certificate does not limit coverage for chemotherapeutic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

**Experimental Treatment** (continued)

How BCBSM Determines If a Treatment Is Experimental

If a treatment is not covered under Section 3, pages 30 and 60, BCBSM's medical director will determine if it is experimental. The director may decide it is experimental if:

- Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
- It is shown to be safe and effective treatment for some conditions. However there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
- Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or
- It is being studied in an on-going clinical trial, or
- The treating provider uses a written informed consent that refers to the treatment, as:
  - Experimental or investigational or
  - Other than conventional or standard treatment.

NOTE The medical director may consider other factors.

When available, these sources are considered in deciding if a treatment is experimental under the above criteria:

- Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
- Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
- Accepted national standards of practice in the medical profession
- Approval by the hospital's or medical center's Institutional Review Board

NOTE The medical director may consider other sources.

**Experimental Treatment** (continued)

Services That Are Payable

We do pay for experimental treatment and its related services when **all** of the following are met:

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- It is covered under your certificates when provided as conventional treatment.
- The services related to the experimental treatment are covered under your certificates when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM), or the related services are routine patient costs that are covered under "Clinical Trials (Routine Patient Costs)" in Section 3.

This certificate does not limit coverage for chemotherapeutic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This section of your certificate does not cover services not otherwise covered under your certificates.
- Drugs or devices given to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, we will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

## *Genetic Testing*

We will not:

- Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you, your spouse or your dependents

## *Grace Period*
If you are not receiving a tax subsidy a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. If you are receiving a tax subsidy, the grace period is three months.

## *Guaranteed Renewability*
Coverage under this certificate is guaranteed renewable.

## *Illness or Injuries Resulting from War*
We do not pay for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

## *Improper Use of Contract*
If you let any ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Terminate or cancel your coverage
- Begin legal action against you
- Refuse to cover your health care services at a later date

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

## *Notice of Claim*
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Please go to: http://www.bcbsm.com/index/health-insurance-help/documents-forms/topics/claims/claim-forms.html to find the address where you should send your notice.

## *Notification*
When we need to notify you, we mail the notice to you or remitting agent or to your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.

## *Payment of Claims*
Indemnity for loss of life will be payable in accordance with the beneficiary designation.

## *Payment of Covered Services*

The services covered under this certificate may be combined and paid according to BCBSM's payment policies. Examples include multiple surgeries or a series of lab tests.

## *Personal Costs*

We will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

## *Pharmacy Fraud, Waste, and Abuse*

We do not pay for the following:

- Prescription drugs that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;
- Drugs prescribed by a prescriber who is sanctioned at the time the prescription is dispensed.

NOTE

Sanctioned prescribers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any prescriber you have received services from during the previous 12 months has been sanctioned. You will be given 30 days' notice, after which we will not pay for prescriptions written by the sanctioned prescriber.

## *Physician of Choice*

You may continue to get services from the physician you choose. However, be sure to get services from an in-network physician to avoid out-of-network costs to you.

## *Proofs of Loss*

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

## *Refunds of Premium*

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

## *Reinstatement*

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

## *Release of Information*

**You agree** to let providers release information to us. This can include medical records and claims information related to services you may receive or have received.

**We agree** to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

## *Reliance on Verbal Communications*

If we tell you a member is eligible for coverage or benefits are available, this does not guarantee your claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Medical necessity is verified
- Benefits are available when the claim is processed.

## *Right to Interpret Contract*

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

## *Semiprivate Room Availability*

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you must pay for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

## *Services Before Coverage Begins or After Coverage Ends*

Unless this certificate states otherwise, we do not pay for any services, treatment, care or supplies provided before your coverage under this certificate begins or after it ends. If your coverage begins or ends while you are an inpatient in an acute care hospital, our payment will be based on our contract with the hospital. It may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**
- Only the services, treatment, care or supplies you receive while your coverage is in effect.

**We pay for only the services, treatment, care or supplies you receive while your coverage is in effect if it begins or ends while you are:**

- An inpatient in a facility such as a hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, **or**
- Being treated for an episode of illness by a home health agency, ESRD facility or outpatient hospital rehabilitation unit or other facility identified by BCBSM.

If you have other coverage when a facility admits or discharges you, it may have to pay for the care you receive before your BCBSM coverage begins or after it ends.

## *Services That are Not Payable*

We do not pay for services that:

- You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate
- Are available in a hospital maintained by the state or federal government, unless payment is required by law
- Can be paid by government-sponsored health care programs, such as Medicare, even if you are eligible; We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage.
- Are not listed in this certificate as being payable

## *Subrogation: When Others are Responsible for Illness or Injury*

If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury, then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

This is BCBSM's right of recovery. BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

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

- You
- Your covered dependents

**You agree to:**

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery.
- Not take action that may prejudice BCBSM's right of recovery.
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact BCBSM promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.

**BCBSM may:**

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM's right of recovery.
- Request you to sign a reimbursement agreement.
- Delay the processing of your claims until you provide a signed copy of the reimbursement agreement.
- Offset future benefits to enforce BCBSM's right of recovery.

**Subrogation: When Others are Responsible for Illness or Injury** (continued)

**BCBSM will:**

- Pay the costs of any covered services you receive that are in excess of any recoveries made.

  *Examples where BCBSM may utilize the subrogation rule are listed above.*

- BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:

  - When a third party injures you, for example, through medical malpractice;
  - When you are injured on premises owned by a third party; or
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to Medical reimbursement coverage.

## *Subscriber Liability*

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

## *Termination of Coverage*

You must notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:

NOTE

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

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or

- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or

- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

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

NOTE

We will not terminate your coverage for any reason other than those listed on pages 7 and 8 of this certificate.

## *Time Limit for Filing Claims*
We will not pay for claims for drugs that are not filed within the following time limits from the date of service:

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

## *Time Limit for Legal Action*
Legal action against us may not begin later than three years after we have received a complete claim for services. No action or lawsuit may be started until 60 days after you notify us that our decision under the claim review procedure is unacceptable.

## *Time Limit on Certain Defenses*
After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.

No claim for loss incurred or disability commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

## *Time of Payment of Claims*
Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

## *Unlicensed and Unauthorized Providers*
We do not pay services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM), or
- Legally authorized or licensed to order or provide such services.

## *What Laws Apply*
This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

## *Workers Compensation*
We do not pay for treatment of work-related injuries covered by workers compensation laws. We do not pay for work-related services you get at an employer's medical clinic or other facility.

# Section 7: Definitions

**This section explains the terms used in your certificate. The terms are listed in alphabetical order.**

**Accidental Injury**
Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

**Acute Care**
Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

**Acute Care Facility**
A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

**Administrative Costs**
Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

**Adverse Benefit Decision**
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

**Affiliate Cancer Center**
A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

**Allogeneic (Allogenic) Transplant**
A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.

**Ambulatory Infusion Center**
A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

**Ambulatory Surgery**
Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a physician's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

**Ambulatory Surgery Facility**
A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.

**Ancillary Services**
Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.

**Approved Amount**
The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

**Approved Clinical Trial**
A Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally-funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the Federal Drug Administration
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Act

**Arthrocentesis**
Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

**Attending Physician**
The physician in charge of a case who exercises overall responsibility for the patient's care:

- Within a facility (such as a hospital and other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

**Audiologist**
A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

**Autism Diagnostic Observation Schedule**
The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the director of the Michigan Department of Insurance and Financial Services, if the director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

**Autism Evaluation Center**
An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
- Recommend an initial high-level treatment plan for member's with autism spectrum disorders.

**Autism Spectrum Disorders**
Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

**Autologous Transplant**
A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

**BCBSM**
Blue Cross Blue Shield of Michigan.

**Behavioral Health Treatment**
Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

**Benefit Period**
The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.

**Biological**
A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

**Birth Year**
A 12-month period of time beginning with a child's month and day of birth.

**BlueCard PPO® Program**
A program that allows Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

**BlueCard Worldwide® Program**
A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

**Blue Cross Plan**
Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

**Blue Shield Plan**
Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

**Board Certified Behavior Analyst**
An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

**Calendar Year**
A period of time beginning January 1 and ending December 31 of the same year.

**Cancellation**
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

**Carrier**
An insurance company providing a health care plan for its members.

**Certificate**
This book, which describes your benefit plan, **and** any riders that amend this certificate.

**Certified Nurse Midwife**
A nurse who provides some maternity services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing

**Certified Nurse Practitioner**
A nurse who provides some medical services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

**Certified Registered Nurse Anesthetist**
A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

**Chronic Condition**
A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

**Claim for Damages**
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

**Clinical Licensed Master's Social Worker**
A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Clinical Trial**
A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, coverage for clinical trials is in accordance with recommendations in the Patient Protection and Affordable Care Act (PPACA) law and includes but is not limited to:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

**Coinsurance**
The portion of the approved amount that you must pay for a covered drug or service. Your coinsurance is not altered by any audit, adjustment, or reprocessing of claim. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

**Colony Stimulating Growth Factors**
Factors that stimulate the multiplication of very young blood cells.

**Congenital Condition**
A condition that exists at birth.

**Contraceptive Device**
A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

**Contraceptive Medication**
Any drug used for the express purpose of preventing pregnancy at the time of its administration.

**Contract**
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

**Contracted Area Hospital**
A BCBSM participating or in-network hospital located in the same area as a noncontracted area hospital.

**Conventional Treatment**
Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

**Coordination Period**
A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

**Copayment**
The dollar amount that you must pay for a covered drug or service. Your copayment is not altered by any audit, adjustment, or reprocessing of claim. For prescription drugs, your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

NOTE

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

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

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

**Cost-sharing**
Copayments, coinsurances, and deductibles you must pay under this certificate.

**Covered Drugs**
Injectable insulin, FDA-approved drug or such drugs that BCBSM designates as covered, if the following conditions are met:

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

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

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

NOTE

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

**Covered Services**
A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

**Custodial Care**
Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

**Deductible**
The amount that you must pay for covered services, under any certificate, before benefits are payable.

**Dental Care**
Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

**Department of Insurance and Financial Services (DIFS)**
The department that regulates insurers in the state of Michigan.

**Designated Cancer Center**
A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

**Designated Facility**
To be a covered benefit, human organ transplants must take place in a “BCBSM-designated” facility. A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.

**Designated Services**
Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

**Detoxification**
The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

**Developmental Condition**
A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

**Diagnostic Agents**
Substances used to diagnose rather than treat a condition or disease.

**Dialysis**
The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

**Direct Supervision**
The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

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

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

**Dual Entitlement**
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

**Durable Medical Equipment**
Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

**Effective Date**
The date your coverage begins under this contract. This date is established by BCBSM.

**Elective Abortion**
Services, devices, drugs or other substances provided by any provider in any location that are intended to terminate a woman's pregnancy for a purpose other than to: preserve the life or health of the child after a live birth; or remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Any service, device, drug or other substance related to an elective abortion is also excluded.

Elective abortions do not include: a prescription drug or device intended as a contraceptive; services, devices, drugs or other substances provided by a physician to terminate a woman's pregnancy because her physical condition, in the physician's reasonable medical judgment, requires that her pregnancy be terminated to avert her death; and treatment of a woman experiencing a miscarriage or who has been diagnosed with an ectopic pregnancy.

**Eligibility**
As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

**Emergency Care**
Care to treat an accidental injury or medical emergency.

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

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

**Emergency Medical Condition**
Emergency Medical Condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)

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

**Emergency Services**
Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

**End Stage Renal Disease (ESRD)**
Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

**Enrollment Date**
The first date of coverage or the first day of the waiting period.

**Entitlement (or Entitled)**
The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

**Essential Health Benefits**
A set of health care service categories that must be covered by health plans under the Affordable Care Act.

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

**Evaluation**
An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

**Exclusions**
Situations, conditions, or services that are not covered by the subscriber's contract.

**Exigent Circumstances**
When you suffer from a health condition that may seriously jeopardize your life, health or your ability to regain maximum function or when you are undergoing a current course of treatment using a drug that is not on BCBSM's drug list.

**Experimental Treatment**
Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

**Facility**
A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.

**Fecal Occult Blood Screening**
A laboratory test to detect blood in feces or stool.

**Federal Food and Drug Administration (FDA)**
An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

**First Degree Relative**
An immediate family member who is directly related to the patient: either a parent, sibling or child.

**First Priority Security Interest**
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

**Flexible Sigmoidoscopy**
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

**Freestanding Outpatient Physical Therapy Facility**
An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

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

**Gynecological Examination**
A history and physical examination of the female genital tract.

**Hazardous Medical Condition**
The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

**Health Maintenance Examination**
A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

**Hematopoietic Transplant**
A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

**Hemodialysis**
The use of a machine to clean wastes from the blood after the kidneys have failed.

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

**High-Dose Chemotherapy**
A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

**High-Risk Patient**
An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

**HLA Genetic Markers**
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

**Home Health Care Agency**
An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

**Hospice**
A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

**Hospital**
A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis **and**
- Is fully licensed and certified as a hospital, as required by all applicable laws **and**
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers
- Skilled nursing facilities or other nursing care facilities

**Hospital privileges**
Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

**Host Blue**
See definition of "Host Plan."

**Host Plan**
A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state. Sometimes referred to as Host Blue.

**In-Network Mail-Order Provider**
A provider who has been selected to provide covered drugs through our PPO mail-order program.

**In-Network Pharmacy**
A provider selected by BCBSM to provide covered drugs through our PPO program. in-network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

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

**Independent Occupational Therapist**
An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Independent Physical Therapist**
A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Independent Speech-Language Pathologist**
A speech-language pathologist who provides some speech-language therapy services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Infusion Therapy**
The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

**Injectable Drugs**
Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

**Irreversible Treatment**
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.

- The treatment is intended to cause permanent change to a person's bite or position of the jaws.

- The treatment includes, but is not limited to:

  - Crowns, inlays, caps, restorations and grinding
  - Orthodontics, such as braces, orthopedic repositioning and traction
  - Installation of removable or fixed appliances such as dentures, partial dentures or bridges
  - Surgery directly to the jaw joint and related anesthesia services
  - Arthrocentesis

**Jaw Joint Disorders**
These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly

- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly

- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

**Licensed Professional Counselor (LPC)**
A licensed professional counselor who provides some mental health services and who:

- Is licensed as a professional counselor by the state of Michigan;

- Meets BCBSM qualification standards;

- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Lien**
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

**Life-threatening Condition**
Any disease or condition from which the likelihood of death is probable unless the course of the disease of condition is interrupted.

**Lifestyle Drugs**
Drugs such as those that treat erectile dysfunction or help a person lose weight.

**Lobar Lung**
A portion of a lung from a cadaver or living donor.

**Long-Term Acute Care Hospital**
A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

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

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

**Mandibular Orthotic Reposition Device**
An appliance used in the treatment of temporomandibular joint dysfunction.

**Maternity Care**
Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

**Maxillofacial Prosthesis**
A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

**Maximum Allowable Cost**
The most BCBSM will pay for generically equivalent drugs covered by BCBSM.

**Medical Emergency**
A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury. Emergency services treat medical emergencies.

**Medical Evidence Report**
A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

**Medical Supplies**
Medically necessary quantities of medical supplies and dressings used for the treatment of a specific medical condition. Medical supplies include but are not limited to gauze, cotton, fabrics, plaster and other materials used in dressings and casts.

**Medically Necessary**
A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

- 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 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.**

- **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 are needed to provide safe and adequate care and treatment.

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

  - The service is not mainly for the convenience of the member or health care provider.
  - The treatment is not generally regarded as experimental by BCBSM.
  - The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

**Medically Necessary Drugs**
A drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or physician.

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

**Member**
Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services.

**Multi-source Drug**
Multi-source drug – a brand-name drug that has a generic available.

**Network Providers**
Also called "in-network providers" See the definition of "In-network Providers" on Page **166**.

**Noncontracted Area Hospital**
A BCBSM nonparticipating and out-of-network hospital located in an area defined by BCBSM.

**Nonparticipating Hospital**
A hospital that has not signed a participation agreement with BCBSM to accept our approved amount as payment in full.

**Nonparticipating Providers**
Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

**Nonpreferred Brand Name Drug**
A nonpreferred brand name drug that is on BCBSM's drug list.

**Occupational Therapy**
A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve, retain or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living, or
- Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, shower chairs, large-handle eating utensils, lap trays and raised toilet seats)

**Off-Label**
The use of a drug or device for clinical indications other than those stated in the labeling approved by the Federal Food and Drug Administration.

**Office of Personnel Management (OPM)**
The federal Office of Personnel Management oversees multi-state plans that are offered on the Marketplace.

**Orthopedic Shoes**
Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

**Orthotic Device**
An appliance worn outside the body to correct a body defect of form or function.

**Out-of-Area Hospital**
A BCBSM in-network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

**Out-of-Area Services**
Services available to members living or traveling outside a health plan's service area.

**Out-of-network Mail Order Provider**
A provider who has not been selected to provide covered drugs through our PPO program. Out-of-network mail-order providers have not agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

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

**Out-of-network Providers**
Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

**Outpatient Mental Health Facility**
A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

**Outpatient Substance Abuse Treatment Program**
A program that provides medical and other services on an outpatient basis specifically for substance abusers.

**Pap Smear**
A method used to detect abnormal conditions, including cancer of the female genital tract.

**Partial Liver**
A portion of the liver taken from a cadaver or living donor.

**Participating Hospital**
A hospital that has signed a participation agreement with BCBSM to accept our approved amount as payment in full. Copayments or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

**Participating PPO Provider**
A provider who participates with the Host Plan's PPO.

**Participating Providers**
Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

**Patient**
The subscriber or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

**Per Claim Participation**
Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

**Period of Crisis**
A period during which a patient requires continuous care (primarily nursing care) to alleviate or manage acute medical symptoms.

**Peripheral Blood Stem Cell Transplant**
A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.

**Peritoneal Dialysis**
Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

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

**Pharmacy and Therapeutics Committee**
A group of physicians, pharmacists and other experts that review drugs for coverage determination.

**Pheresis**
Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

**Physical Therapist**
A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

**Physical Therapy**
The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to keep, learn, retain or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility

**Physician**
A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as “practitioners.”

**Plaintiff**
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

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

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

**Practitioner**
A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master’s social worker, licensed professional counselor or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as “participating” or “in-network” provider.

**Pre-existing Condition**
A condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.

**Preapproval**
A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained **before** you receive certain services described in this rider, they will not be covered.

**Preferred Brand Name Drug**
A preferred brand name drug that is on BCBSM’s drug list.

**Preferred Provider Organization (PPO)**
A limited group of health care providers or pharmacies who have agreed to provide covered drugs or services to BCBSM members enrolled in the PPO program. These providers or pharmacies accept the approved amount as payment in full for covered drugs or services.

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

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

**Presurgical Consultation**
A consultation that allows a member to get an additional opinion from a physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon** when surgery is recommended.

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

**Primary Plan**
The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

**Prior Authorization Process**
A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

**Professional Provider**
One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Clinical licensed master's social worker
- Licensed Professional Counselor (LPC)
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

**Prosthetic Device**
An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

**Protocol**
A detailed plan of a medical experiment or treatment.

**Provider**
A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care or a pharmacy legally licensed to dispense drugs.

**Provider-Delivered Care Management (PDCM)**
A program that enables patients to receive care management from a trained clinical care manager in collaboration with, and coordinated by, your primary care physician.

**Psychiatric Day Treatment**
Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.

**Psychiatric Night Treatment**
Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.

**Psychiatric Residential Treatment Facility**
A facility that provides residents with 24-hour mental health care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

**Psychologist**
A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

**Purging**
A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

**Qualified Individual**
An individual eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
- The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols

**Qualifying Event**
One of the following events that allows a qualified beneficiary to receive coverage:

- Birth
- Death of the member
- Divorce
- Loss of dependent status due to age, location of residence, marriage, etc.
- The member becomes entitled to coverage under Medicare

**Radiology Services**
These include X-ray exams, radium, nuclear cardiac studies, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

**Refractory Patient**
An individual who does not achieve clinical disappearance of the disease after standard therapy.

**Registered Provider**
A participating or nonparticipating provider that is an in-network or out-of-network PPO provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

**Relapse**
When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

**Remitting Agent**
Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber and
- Pay the subscriber's BCBSM bill

**Rescission**
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

**Research Management**
Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

**Residential Substance Abuse Treatment Program**
A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."

**Respite Care**
Relief to family members or other persons caring for terminally ill persons at home.

**Reversible Treatment**
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is **not** intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:
  - Arthrocentesis
  - Physical therapy (see Page 69 for physical therapy services)
  - Reversible appliance therapy (mandibular orthotic repositioning)

**Rider**
A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

**Right of Recovery**
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

**Routine Patient Costs** means all items and services related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**Sanctioned Prescriber**
Any provider who has been disciplined under Section 1128 and Section 1902(a)(39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

**Screening Services**
Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

**Secondary Plan**
The health care plan obligated to pay for services after the primary plan has paid for services.

**Select Prescription Drugs Requiring Prior Authorization**
Prescription drugs identified by BCBSM as requiring prior authorization. A description of the drugs and the criteria for approval are provided in a list that is updated periodically by BCBSM. Your physician or pharmacist can call us for this list.

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

**Self-Dialysis Training**
Teaching a member to conduct dialysis on himself or herself.

**Semiprivate Room**
A hospital room with two beds.

**Service Area**
The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE

BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

**Services**
Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

**Skilled Care**
A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- Ordered by the attending physician
- Medically necessary according to generally accepted standards of medical practice
- Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

**Skilled Nursing Facility**
A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

**Small Bowel Transplant**
A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.

**Special Medical Foods**
Special foods that are formulated for the dietary treatment of inborn errors of metabolism. The nutritional requirements of the patient are established by a physician's medical evaluation of the patient. The diet must be administered under the supervision of a physician.

**Specialty Hospitals**
Hospitals that treat specific diseases, such as mental illness.

**Specialty Pharmaceuticals**
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but exclude injectable insulin. **Select specialty pharmaceuticals require prior authorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

NOTE

BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

**Specialty Pharmacy**
Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

**Speech and Language Pathology Services**
Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

**Spouse**
An individual who is legally married to the subscriber.

**Stabilize**
Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

**Stem Cells**
Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood components including red cells, white cells and platelets.

**Subrogation**
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

**Subscriber**
The person who signed and submitted the application for coverage.

**Substance Abuse**
Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance abuse is alcohol or drug abuse or dependence as classified in the most current edition of the “International Classification of Diseases.”

NOTE Tobacco addictions are included in this definition.

**Substance Abuse Treatment Program Services**
Subacute services to restore a person's mental and physical well-being when the person is a substance abuser. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

**Syngeneic Transplant**
A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

**Tandem Transplant**
A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

**T-Cell Depleted Infusion**
A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

**Technical Surgical Assistance**
Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

NOTE Professional active assistance requires direct physical contact with the patient.

**Terminally Ill**
A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

**Termination**
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

**Therapeutic Shoes**
Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.

**Total Body Irradiation**
A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

**Treatment Plan**
A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Treatment Plan for Autism Disorders
A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

**Urgent Care**
Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors' offices.

**Valid Application**
An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

**Voluntary Sterilization**
Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

**Waiting Period**
Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

**Ward**
A hospital room with three or more beds.

**We, Us, Our**
Used when referring to Blue Cross Blue Shield of Michigan.

**Well-Baby Care**
Services provided in a physician's office to monitor the health and growth of a healthy child.

**Working Aged**
Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

**Working Disabled**
Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

**You and Your**
Used when referring to any person covered under the subscriber's contract.

# Section 8: Additional Information You Should Know About Your Coverage

We want you to be satisfied with how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number is on the back of your Blues ID and in the top right hand corner of your Explanation of Benefit Payments statements.

## *Grievance and Appeals Process*

We have a formal grievance and appeals process through BCBSM Customer Service. This process allows you to resolve issues that you could not resolve through Customer Service. You can also dispute an adverse benefit decision or termination or cancellation of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for an entire service or part of a service, or
- Decision to terminate or cancel overage for these reasons:
  - You or your dependents are not eligible for coverage under a plan.
  - A utilization review revealed the benefit should not have been paid.
  - We determined the service to be experimental, investigational, or not medically necessary or appropriate.

You may file a grievance or appeal about any adverse benefit decision. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in our review
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- 
- Although we have 35 days to give you our final determination, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to BCBSM's decision to deny, reduce or terminate or cancel your coverage.

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the U.S. Office of Personnel Management.

**Standard Internal Review Process**

**Step 1:** You or your authorized representative sends us a written statement explaining why you disagree with our decision.

Mail your written grievance to:

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

**Step 2:** We will contact you to schedule a conference once we receive your grievance. During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at our office in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

**Step 3:** If you disagree with our final decision, or you do not receive our decision within 35 days after we received your original grievance, you may request an external review. See below for how to request an external review.

**Standard External Review Process**

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

Before you file a request for an external review, you must exhaust the internal review process above, unless:

1. We waive the exhaustion requirement

2. We fail to comply with the requirements of our internal appeals process, unless those failures are legally insignificant, or

3. You simultaneously request an expedited internal review and an expedited external review

You may ask for a review of any adverse benefit decision as defined above, or any rescission of your coverage. There is no fee to request an external review.

**Standard External Review Process** (continued)

The standard external review process is as follows:

- Within 1 year of the date you receive or should have received the final decision, send a written request for an external review to the OPM listed below. You may ask for a review more than 1 year after our final determination if you provide a reasonable explanation why you did not request a review within the first year.

  Your request for review should include:

  - A statement about why you believe our decision was wrong, based on specific benefit provisions in this certificate.
  - Copies of documents that support your complaint, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
  - Copies of all letters you sent to us about the complaint;
  - Copies of all letters we sent to you about the complaint;
  - Your daytime phone number and the best time to call; and
  - Your email address, if you would like to receive OPM's decision via email.

  NOTE By providing your email address, you may receive OPM's decision more quickly.

  Submit your request to OPM via e-mail at mspp@opm.gov, via fax at 1-855-318-0714, or mail your request to:

  MSPP External Review
  National Healthcare Operations
  U.S. Office of Personnel Management
  1900 E Street, NW
  Washington, DC 20415

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

**Reviews of Medical Issues**

If you ask for an external review related to a medical issue and the issue is found to be appropriate for external review, OPM will assign an Independent Review Organization (IRO) to conduct the external review. The IRO will consist of independent clinical peer reviewers. The decision of the IRO will be binding on you and BCBSM, except to the extent other remedies are available under state or federal law. OPM will make sure that the IRO does not have a conflict of interest with you, with us, or with any other relevant party.

**Step 1:** OPM will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You will have the opportunity to provide more information to the OPM within calendar 20 days of sending your request for an external review.

**Reviews of Medical Issues** (continued)

**Step 2:** OPM will notify you, and us, within 30 calendar days of getting your request for external review. For reviews involving a medical issue, an independent review group will have 15 calendar days to provide a decision after getting the request from OPM. This organization's 15 days are counted as part of OPM's 30 days.

**Reviews of Nonmedical Issues**

If you ask for an external review that is related to nonmedical issues, and it was denied based on your coverage, OPM will provide a binding decision.

For more information on the external review process, go to:
http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/.

**Expedited Internal Review Process**

- You may file a request for an expedited internal review if your physician shows (verbally or in writing) that the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process to submit an expedited internal review is as follows:

**Step 1:** Call 313-225-6800 to ask for an expedited review. Your physician should also call this number to confirm that you qualify for an expedited review.

**Step 2:** We must give you our decision within 72 hours of getting both your grievance and the physician's substantiation.

**Step 3:** If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the U.S. Office of Personnel Management.

**Expedited External Review Process**

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Office of Personnel Management. You do not need to wait for a decision on your expedited internal review before filing a request for external review.

Your request for an external review must have evidence from your provider that your situation is urgent. An urgent situation is one in which your health may be at serious risk while you wait for a decision on the external review of your claim.

The process is as follows:

**Step 1:** Once you have filed a request for an expedited internal review, send a written request for an expedited external review to OPM. In addition to your provider's evidence, this request should include:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this certificate
- Copies of documents that support your complaint, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms
- Copies of all letters you sent to us about the complaint
- Copies of all letters we sent to you about the complaint
- Your daytime phone number and the best time to call
- Your email address, if you would like to receive OPM's decision via email

By providing your email address, you may receive OPM's decision more quickly.

**Expedited External Review Process** (continued)

**Step: 2** Submit your request to OPM via e-mail at mspp@opm.gov, via fax at 1-855-318-0714, or mail your request and the documents requested in Step 1 to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

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

**Step 3:** The OPM will decide if your request is appropriate for an external review. If it does, the OPM will assign an Independent Review Organization (IRO) to conduct the expedited external review. The IRO will review your request and advise within 72 hours if the OPM should uphold or reverse our decision.

**Step 4:** Within that 72 hour timeframe, OPM will tell you about their final and binding decision.

For more information on the external review process, go to:
http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/.

## *Pre-Service Appeals*

**For members who must get approval before obtaining certain health services**.

Your plan may require preapproval of certain health services. If preapproval is denied, you can appeal this decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the customer service number on the back of your Blues ID card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not pre-approved.

**Requesting a Standard Pre-Service Review**

You may make the request yourself, or your physician or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your request for a review must include:

- Your contract number, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name if different from yours
- A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal, we will provide you with our final decision within 30 days.

**Requesting an Urgent Pre-Service Review**

If your situation meets the definition of urgent under the law, your review will be conducted as soon as possible; generally within 72 hours. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the customer service number listed on the back of your Blues ID card.

**Need More Information?**

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the customer service number on the back of your Blues ID card.

**Other resources to help you**

For questions about your rights, this notice, or for assistance, you can call the U.S. Office of Personnel Management at 1-855-318-0714.

# Section 9: How to Reach Us

**This section lists phone numbers and addresses to help you get information quickly. You may call or visit our BCBSM Customer Service center.**

## *To Call*

Please have your BCBSM ID card ready, showing your contract number when you call. Our hours of operation are subject to change based on servicing our member's needs. Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to 5 p.m., Monday through Friday.

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

**For when you are out-of-state, call BlueCard** .....800-810-2583

**For when you are out of the country, call BlueCard Worldwide**..... 804-673--1177 (call collect)

## *To Write*

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

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