Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

SIMPLY BLUE℠ HSA GROUP BENEFITS CERTIFICATE with PRESCRIPTION DRUGS SG

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

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 Need to Know**
- **How to Reach Us**
- **Index**

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

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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 to Receive Benefits
  - Changing Your Coverage
  - End Stage Renal Disease (ESRD)
- TERMINATION
  - How to Terminate Coverage
  - How We Terminate Your Coverage
  - Rescission
- **CONTINUATION OF BENEFITS**
  - Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Individual Coverage

ELIGIBILITY

Who is Eligible to Receive Benefits

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

NOTE A person who marries a member who already has coverage as a surviving spouse is not eligible for benefits.

You will need to fill out an application for coverage.

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

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 7.

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

- Birth
- Marriage
- Legal adoption
- Legal guardianship.

NOTE Your child’s spouse and your grandchildren are not covered 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 Your employer must send us a physician’s certification proving the child’s disability. We must receive it by 31 days after the end of the year of the child’s 26th birthday. We will decide if the child meets the requirements.

Who is Eligible to Receive Benefits (continued)

You may also be eligible for group coverage if:

- You lose your Medicaid coverage (you must apply for BCBSM coverage within 60 days)
- Your dependents lose their CHIP coverage (Children's Health Insurance Program) (you must apply for BCBSM coverage within 60 days)
- You or your dependent becomes eligible for premium subsidies.

Changing Your Coverage

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

- Birth
- Adoption
- Marriage
- Divorce
- The death of a member
- Start of military service

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

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

If a dependent cannot be covered by your contract anymore, he or she may be able to get his or her own contract.

End Stage Renal Disease (ESRD)

We coordinate with Medicare to pay for ESRD treatment. This includes hemodialysis and peritoneal dialysis. The member should apply for Medicare to keep costs down. Dialysis services must be provided in:

- A participating hospital
- A participating freestanding ESRD facility
- In the home.

The member should apply for Medicare to keep costs down; otherwise he or she will be responsible for paying the cost of ESRD treatment (see page 163).

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.

When BCBSM Coverage is the Primary or Secondary Plan

If you have BCBSM group coverage through your job and you are entitled to Medicare because you have ESRD, BCBSM is your primary plan. That means BCBSM pays for all covered services for up to 33 months. (The three month “waiting period” and 30 month “coordination period”.) After the coordination period, Medicare is your primary plan and pays for all covered services.

The coordination period may be less than 30 months. The medical evidence report your physician fills out helps determine how long it is.

End Stage Renal Disease (continued)

Dual Entitlement

If you have dual entitlement to Medicare and have employer group coverage, the following applies:

- If you are entitled to Medicare because you have ESRD and
- Your entitlement starts at the same time or before you are entitled to Medicare because of your age or disability,
- Your employer health plan is the primary plan. It is primary until the end of the 30-month coordination period.

You retired at age 62 and kept your employer health plan as a retiree. You start dialysis on June 12, 2014. (This begins the three-month waiting period.) On Sept. 1, 2014 you become entitled to Medicare because you have ESRD. (This begins the 30-month coordination period.) Your 65th birthday is in February 2015. On your birthday you also become entitled to Medicare because you turn 65. Since you turned 65 during the 30 months (instead of before), your employer plan is your primary plan for the entire 30 months. On March 1, 2017 Medicare becomes your primary plan.

- If you become entitled to Medicare because you have ESRD after you are entitled to Medicare because of your age or disability:
  - Your employer health plan is your primary plan for the 30 month coordination period if:
    - You are “working aged”
    - You are “working disabled”

You became entitled to Medicare in June 2012 when you turned 65. You are still working. You have employer health coverage. Your employer coverage is your primary plan. On May 27, 2014, you are diagnosed with ESRD and begin dialysis. On Aug. 1, 2014 (after 3 months) you again become entitled to Medicare because you have ESRD. Your employer health plan remains your primary plan through Jan. 31, 2017. Medicare becomes primary on Feb. 1, 2017.

  - If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

You retired at age 62. You have employer health coverage as a retiree. You turn 65 in August 2014 and become entitled to Medicare. Medicare is now your primary plan. You are diagnosed with ESRD in January 2015. You start dialysis. On April 1, 2015, you again become entitled to Medicare because you have ESRD. Medicare remains your primary plan permanently.

TERMINATION

How to Terminate Coverage

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

How We Terminate Your Coverage

We may terminate your coverage if:

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

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

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

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

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

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

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

Rescission

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

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

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

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that applies to most employers with 20 or more employees. It allows you to continue your employer group coverage if you lose it due to a qualifying event; e.g., you are laid off or fired. (Qualifying events" are listed on page 196.) Your employer must send you a COBRA notice. You have 60 days to choose to continue your coverage. The deadline is 60 days after you lose coverage or 60 days after your employer sends you the notice, whichever is later. If you choose to keep the group coverage you must pay for it. The periods of time you may keep it for are:

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) (continue)

COBRA coverage can be terminated because:

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

Please contact your employer for more details about COBRA.

Individual Coverage

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

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 a **PPO 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. You will pay the least out-of-pocket costs: • Lower deductible amounts • Lower coinsurance amounts • No deductible or coinsurance for certain preventive care benefits No claim forms to file	Provider accepts the BCBSM approved amount as payment in full. You will pay more out-of-pocket costs than what you pay if you see an in-network provider • A higher deductible, unless noted • Increased out-of-network coinsurance amounts No claim forms to file	Provider does not accept the BCBSM approved amount as payment in full** You will pay the highest out-of-pocket: • A higher deductible • You pay all charges that exceed the amount we pay for a service. • Increased coinsurance amounts, unless noted (e.g., see emergency services on Page 105). You must file claim forms
Important:** 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 plus out-of-network cost-sharing. * 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. You must pay the out-of-network cost-sharing.		

Section 4 on page 140 explains more about providers: professional providers, hospitals and others. We also explain how we pay providers.

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

The deductibles 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.

Cost-Sharing Chart		
	In-network	Out-of-network
Deductibles	$1,300 for a one member contract $2,600 for a family contract (when two or more members)	$2,600 for a one member contract $5,200 for a family contract (when two or more members)
Coinsurance	20% of approved amount for most covered services 50% of approved amount for bariatric surgery	40% of approved amount for most covered services 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums	$2,300 for one member contract $4,600 for a family contract (when two or more members)	$4,600 for a one member contract $9,200 for a family contract (when two or more members)
Lifetime dollar maximum	None	

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

Some services have different cost-sharing. These are listed starting on page 13.

Deductible Requirements

You have an HSA plan, your deductible requirement is based on the deductible amounts allowed by federal government each year. Call your customer service center anytime for an update.

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

We begin paying for services only after the total amount of the deductible has been met.

Your deductible does not apply to:

- Other certificate cost-share requirements

Deductible Requirements (continued)

In-Network Providers

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

- $1,300 for a one member contract
- $2,600 for a family contract (when two or more members are covered under your contract)
  - One or more members must meet the family deductible

Out-of-network Providers

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

- $2,600 for a one member contract
- $5,200 for a family contract (when two or more members are covered under your contract)
  - One or more members must meet the family deductible

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

- 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, or
- The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

NOTE

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

You may contact BCBSM for more information about these services.

Coinsurance Requirements

Your coinsurance does not apply to:

- Other certificate cost-share requirements

In addition to deductibles, you must also pay coinsurance for in- and out-of-network services.

In-network Providers

- 20 percent of the approved amount for most covered services
- 50% of approved amount for bariatric surgery

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

Out-of-network Providers

- 40 percent of the approved amount for most covered services

  You will not be required to pay this coinsurance for covered out-of-network services when:

  - Services from a provider for which there is no PPO network.
  - 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. Page 144 explains what we pay for emergency services in a nonparticipating hospital.
  - 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.

The coinsurance for these services will be the same as that paid for covered services provided by in-network providers.

- 50% of approved amount for bariatric surgery

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

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

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

NOTE

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

Benefit-Specific Cost-Sharing Requirements

The benefits below differ in what you pay for them:

Contraceptive Devices and Injections

When received in-network, you do not pay any cost-sharing for devices or injections.

When out-of-network, you do need to pay your out-of-network deductible and coinsurance.

Mental Health Services and Substance Use Disorder Treatment Services

You pay the same cost-sharing for mental health services and substance use disorder treatment that you would for all other covered services, in-network or out-of-network.

Prescription Drugs

See the "Prescription Drugs" section beginning on Page 80 for conditions affecting what you pay for prescribed drugs.

What you pay for the prescription drugs that we cover is defined in this certificate or in a rider(s) that amends this certificate.

Value Based Programs

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

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

Benefit-Specific Cost-Sharing Requirements (continued)

Voluntary Sterilization for Females

We pay for voluntary sterilizations for females. We cover services from a physician and in a participating hospital.

- When received in-network, you pay no cost-sharing.
- When out-of-network, you pay out-of-network cost-sharing.

Annual Maximums

Out-of-pocket Maximums for In-network Services

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

- $2,300 for a one member contract
- $4,600 for a family contract (when two or more members are covered under your contract)

The in-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual in-network maximum. This includes those for prescription drugs. The following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- The 20 percent member liability for covered drugs obtained from a nonparticipating pharmacy.

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

Annual Maximums (continued)

Out-of-pocket Maximums for Out-of-network Services

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

- $4,600 for a one member contract
- $9,200 for a family contract (when two or more members are covered under your contract)

The out-of-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual out-of-network maximum. This includes those for prescription drugs. The following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- The 20 percent member liability for covered drugs obtained from a nonparticipating pharmacy.

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

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

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

Section 3: What BCBSM Pays For

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

- We pay for 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.

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

For other diagnostic services, see Page 34.

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

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

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

For emergency treatment services, see Page 41.

We pay for:

Ground and air ambulance services to transport or transfer 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.

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
  – The patient's home

  NOTE Transfer of the patient must be prescribed by the attending physician.

- The service must be provided in a vehicle licensed as a ground or air ambulance and which is part of a licensed ambulance operation.

We also pay for 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.

Ambulance Services (continued)

We pay for: (continued)

Air Ambulance

Air ambulance services must also meet these requirements:

- No other means of transportation are available or the patient's condition requires transport or transfer by air ambulance rather than ground ambulance
- The provider is not a commercial airline
- The patient is taken to the nearest facility capable of treating the patient's condition. The facility must be:
  - The nearest available facility or
  - Another appropriate facility within a reasonable distance of the nearest available facility.

BCBSM will determine whether a facility is appropriate and what a reasonable distance is.

Your coverage includes BCBSM's case management program. Air ambulance transportation that does not meet the requirements described above is eligible for review and possible approval under the case management provision of your coverage.

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 9 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:

- Participating 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 participating hospital setting
    - Outpatient participating 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 of a physician or anesthesiologist

  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

  We pay for covered anesthesiology services performed by a CRNA in a physician's office.

  Anesthesia services may also be covered as part of electroshock therapy (see Page 55) and for covered dental services (see Page 32).

Audiologist Services

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

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

- In a physician's office
- At other approved outpatient locations.

We pay for:

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

Autism Disorders

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

Treatment includes the following evidence-based care if prescribed by a licensed physician or licensed psychologist:

NOTE For BCBSM to pay for the following services, a BCBSM-approved autism evaluation center must confirm that the member has one of the covered 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 analyst. 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 (continued)

- Applied behavior analysis (ABA) 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.
  - **Preapproval** – 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** - It includes 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, occupational therapy, speech 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 9 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

We pay for:

- Cardiac rehabilitation services that began during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Cardiac or pulmonary rehabilitation services given when intensive monitoring and/or supervision during exercise is required. Services may be given in:
  - An outpatient hospital setting
  - An in-network physician's office
  - A physician-directed clinic (one in which a physician is on-site)

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 per year for combined outpatient cardiac or pulmonary rehabilitation services

Chemotherapy

For high dose chemotherapy used in bone marrow transplants, see Pages 128 – 130.

See Section 2 beginning on Page 9 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 Chemotherapy Specialty Pharmaceuticals described on Page 87.

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 39 to 40.

We pay for the outpatient treatment of breast cancer.

Chiropractic Services and Osteopathic Manipulative Therapy

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

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 76.
When received with occupational therapy, see Page 61.

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: If your coverage limits the number of medical office visits you may receive, chiropractic office visits also applies to that limit (Please see "Office, Outpatient and Home Medical Care Visits" on Page 65). 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.

Physical therapy is either habilitative or rehabilitative depending on the reason why it is provided. You have a 30-visit benefit limit per member, per year for **rehabilitative** physical therapy, occupational therapy, chiropractic manipulations and osteopathic manipulations (in-network and out-of-network providers combined).

You have a separate 30-visit benefit limit per member, per year for **habilitative** physical therapy and occupational therapy (in-network and out-of-network providers combined).

Chiropractic and osteopathic manipulations and traction are always considered rehabilitative.

Chiropractic Services and Osteopathic Manipulative Therapy (continued)

We pay for: (continued)

- 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 9 for what you may be required to pay for these services.
Locations: We pay for services to manage chronic diseases in:

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

We pay for chronic disease management services provided by:

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

Clinical Trials (Routine Patient Costs)

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

For oncology clinical trial services, see Page 67.

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 benefits subject to the conditions described below.

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 participating or in-network. An exception would be if the trial is conducted outside of Michigan.**

Contraceptive Services

See Page 13 in Section 2 for what you may be required to pay for these services.

We pay for contraceptive services for women as part of your preventive care benefit. Please see the preventive care benefit description of contraceptive services on Page 100 for more details.

Dental Services

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

For dental surgery, see Page 119.

Locations: We pay for emergency dental care given in:

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

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

We pay for:

- Emergency Dental Care

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

  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 participating 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 participating 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

Dental Services (continued)

We pay for: (continued)

- Other Dental Services
  - Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:
    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
    - Diagnostic X-rays
    - Physical therapy (see Page 76 for physical therapy services)
    - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

We do not pay for:

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

Diagnostic Services

For allergy testing services, see Page 17.

For diagnostic radiology services, see Page 106.

For mental health diagnostic services, such as psychological testing, see Page 55.

See Section 2 beginning on Page 9 *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 participating hospital (inpatient or outpatient)
- A participating ambulatory surgery facility
- A participating skilled nursing facility
- A physician's office.

We pay for:

Diagnostic Testing

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

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

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

Dialysis Services

See Section 2 beginning on Page 9 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 5 for a detailed explanation of ESRD.)

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

- A participating hospital (inpatient or outpatient)
- A participating freestanding ESRD facility
- A home

We pay for:

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

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

  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 5 for details about ESRD.

  ESRD treatment may be provided in:

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

Dialysis Services (continued)

Services Provided in a Freestanding ESRD Facility

We pay for ESRD treatment in a freestanding facility. This includes facility services. The facility must be in-network or participating with BCBSM. (See Section 2 for how these services are paid).

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
- 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

We do not pay for:

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

Dialysis Services (continued)

Services Provided in the Home

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

- The treatment must be arranged by the 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:

- 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 "back ups" including hospital personnel sent to the patient's home
- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the patient's home
- Physician services not paid by the hospital

Durable Medical Equipment

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

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

- Participating hospital (inpatient or outpatient)
- Participating skilled nursing facility (see Page 108)
- In the home or for home infusion therapy (see Page 44).
- Hospice care (see Page 44)

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
- Medicare Part B: 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.

If the equipment is:

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

Durable Medical Equipment (continued)

We pay for: (continued)

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

- We will cover the rental fee only for the CPAP device. Our total rental payments will not exceed our approved amount to purchase the device. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device.
  - We will pay for the rental or purchase of a humidifier for the CPAP device, if needed.
  - We will pay for the purchase of any related supplies and accessories.
- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier or your physician 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 9 for what you may be required to pay for these services.

For urgent care services, please see Page 135.

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

For a definition of "emergency services," see Page 178.

Gender Dysphoria Treatment

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

We pay for:

BCBSM covers medically necessary services, including prescription drug services, for the treatment of gender dysphoria. This includes professional and facility services.

We will not pay for the following:

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

See Section 7 (Definitions) for an explanation of “gender dysphoria,” “medically necessary,” and “experimental treatment.”

Home Health Care Services

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

Locations: We pay for care and services provided in the patient's home. Home health care provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home. 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
- The following when provided for rehabilitation:
  - Occupational therapy, Page 61
  - Physical therapy, Page 76
  - Speech and language pathology services, Page 109

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

Home Health Care Services (continued)

We pay for: (continued)

- If physical, occupational or speech therapy cannot be done in the home, we will pay for outpatient therapy. It may be in an outpatient department of a hospital or a physical therapy facility. Benefits are subject to the 30-visit maximum as described on Page 61, 76, and 109.

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

- 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

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

- 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

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 member's home

We pay for services to care for the terminally ill. Services must be provided through a participating hospice program. Hospice care services are payable for 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

Hospice Care Services (continued)

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

- 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 participating 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

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

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.

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

Hospice Care Services (continued)

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.

We do not pay for services:

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

For services in a long-term acute care hospital (LTACH), see Page 52.

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 118).

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

We pay for:

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

- Outpatient hospital services:

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

  - Repeated visits to the hospital to treat chronic conditions.

- 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 122 for more information.

Infertility Treatment

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

Locations: We pay for 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:

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

They include but are not limited to:

- 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

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

BCBSM may require that you obtain approval for your in-network infusion therapy services. Your in-network provider is responsible for obtaining approval for this service. For a more detailed explanation, see *Prior Authorization for Specialty Pharmaceuticals* in the *Prescription Drugs* section.

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

Locations: We pay for infusion therapy services:

- In a participating ambulatory infusion center or
- From a participating home infusion provider whether or not you are confined to the home (See Page 154 for when services may be payable in a nursing home.)
- In a physician's office
- In a participating hospital (inpatient or outpatient)

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 87.
- 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 under other benefits 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 9 for what you may be required to pay for these services.
Long-term acute care hospital services count toward any benefit maximums that apply to inpatient hospital services.

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

We pay for:

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

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 use disorder condition

Maternity Care

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

Locations: We pay for facility and professional services in an inpatient participating hospital or participating birthing center for maternity care and related services.

- Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother 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 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

  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 participating hospital setting
    - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
  - Pre-natal care, including maternity education provided in a physician's office as part of a pre-natal visit
  - Post-natal care, including a Papanicolau (Pap) smear during the six-week visit

We do not pay for:

- Lamaze, parenting or other similar classes

Medical Supplies

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

For medical supplies for outpatient diabetes treatment, see Page 73.
For medical supplies for home infusion therapy, see Page 44.

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

- A participating hospital
- A participating hospice
- A participating facility
- A participating skilled nursing facility
- A physician's office or in the home.

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

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

Mental Health Services

See Page 13 in Section 2 for what you may be required to pay for these services.

For autism disorders, please see Page 21.
For substance use disorder services, please see Page 114.
For emergency services to treat mental health conditions, please see page 41.

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

- A participating inpatient hospital
- A participating outpatient setting
- A participating psychiatric residential treatment facility (PRTF)
- A physician's, fully licensed psychologist's, certified nurse practitioner's (CNP), clinical licensed masters social worker's (CLMSW), or licensed professional counselor's (LPC) office
- A participating outpatient psychiatric care (OPC) facility.

BCBSM covers medically necessary and medically appropriate services to evaluate, diagnose, and treat mental health conditions that are in accordance with generally accepted standards of practice.

Medically necessary covered services are those considered by a professional provider, exercising prudent clinical judgment, as clinically appropriate, and are considered effective for the member's illness, injury, or disease. The services must not be more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results.

For diagnostic testing, the results must be essential to, and used in the diagnosis or management of, the patient's condition.

BCBSM does not cover treatment or services that:

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

See Section 7: Definitions for an explanation of "medically necessary" and "experimental treatment."

When you receive mental health or substance use disorder services under a case management agreement that you, your provider and a BCBSM case manager have signed, you will pay your in-network cost-share even if the provider is out-of-network and/or does not participate with BCBSM.

Mental Health Services (continued)

We pay for:

- **Inpatient hospital-mental health services**

  The following inpatient mental health services are payable when provided by a physician or by a fully licensed psychologist who has hospital privileges:

  - 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
  - Electroconvulsive therapy (ECT) 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.

  We do not pay for:

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

- **Psychiatric residential treatment**

  Psychiatric residential treatment is covered only after it has been preapproved 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

Mental Health Services (continued)

Psychiatric residential treatment (continued)

We do not pay for:

- 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 treatment facility or services by the facility that are not preapproved before they occur. BCBSM or its representative must issue the preapproval.
    - If preapproval 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 or treatment that are cognitive in nature or supplies related to such services or treatment
- Court-ordered services
- Treatment or supplies that do not meet BCBSM requirements
- Transitional living centers such as half-way and three-quarter way houses
- Therapeutic boarding schools
- Milieu therapies, such as wilderness program, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- 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
- Services provided by a nonparticipating psychiatric residential treatment facility
- Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

Mental Health Services (continued)

- **Psychiatric partial hospitalization (PHP) treatment program**

  Psychiatric partial hospitalizations are covered only in hospitals and outpatient psychiatric care facilities that participate with BCBSM and have **a PHP program**

  We pay for:

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

    NOTE The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.

  - Family counseling for members of patient's family

  Electroconvulsive Therapy (ECT)

  We pay for ECT in an inpatient or outpatient hospital location.

  We pay for:

  - ECT when administered by, or under the supervision, of a physician
  - Anesthetics for ECT when administered by, or under the supervision of, a physician other than the physician giving the ECT

Mental Health Services (continued)

- **Outpatient Psychiatric Care Facility and Office Setting for Mental Health Services**

  We only pay for services in a **participating** outpatient psychiatric care facility and office setting for mental health services. (See Page 21 for special rules that apply to autism disorders.)

  We pay for:

  – Services provided by the facility's staff
  – Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider as determined by BCBSM in an office setting or a participating outpatient psychiatric care facility:

    - Individual psychotherapeutic treatment
    - Family counseling for members of a patient's family
    - Group psychotherapeutic treatment
    - Psychological testing

  NOTE

  The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.

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

  We do not pay for:

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

Newborn Care

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

Locations: We pay for facility and professional services in a participating inpatient hospital or participating birthing center for routine newborn nursery care during an eligible hospital stay.

Newborn care 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 a newborn child to less than:

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

However, we may pay for a shorter stay if the attending physician or midwife discharges the 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:

- Newborn Examination

  The exam must be given by a physician other than the anesthesiologist or the mother's attending physician.

- Routine Care

  Routine care during the newborn's inpatient hospital stay.

The baby must be eligible for coverage and must be added to your contract within the time stated in your certificate (See "Eligibility.") for newborn care to be covered.

Occupational Therapy

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

For physical therapy services, see Page 76.
For speech-language pathology services, see Page 109.
For chiropractic services and osteopathic manipulative therapy, see Page 27
Special rules apply when occupational therapy services are provided to treat autism (see Page 21).

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

We pay for:

- Medically necessary occupational therapy services subject to conditions described further down in this section
- A maximum of 30 habilitative and 30 rehabilitative outpatient visits per member per year.

Occupational Therapy (continued)

We pay for: (continued)

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

- **Occupational therapy**
- **Physical therapy**
- **All chiropractic manipulations** (rehabilitative only)
- **Osteopathic manipulative therapy** (rehabilitative only)

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will accumulate against the visit maximum.

If services in a member's home are billed by a home health care agency, they will not accumulate against the visit maximum.

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

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

Occupational therapy must be:

- For inpatient services, prescribed by a professional provider licensed to prescribe occupational therapy services
- For outpatient services, prescribed by a professional provider licensed to prescribe occupational therapy services
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning.

Occupational Therapy (continued)

Occupational therapy must be: (continued)

- 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.

  - An athletic trainer under the direct supervision of an occupational therapist in an outpatient setting

We do not pay for:

- More than 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
- Therapy billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate
- Therapy billed as a habilitative service when it does not meet the definition of habilitative in this certificate
- Therapy that is performed without an occupational therapy treatment plan 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
- Services provided to you in the home when services may be payable in a nursing home
- Services received from a nonparticipating hospital or nonparticipating freestanding outpatient physical therapy facility
- Services received from other facilities independent of a hospital
- Services received from an independent sports medicine clinic

Occupational Therapy (continued)

We do not pay for: (continued)

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

  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, Outpatient and Home Medical Care Visits

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

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

- Office visits
- Urgent care visits
- Office consultations
- Outpatient visits
- Home medical care visits
- Online visits
- Visits in a retail health clinic
- Therapeutic injections

NOTE

First aid and medical emergency treatment will **not** require any coinsurance when provided in an out-of-network physician or eligible professional provider's office.

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury.

Online Visits
We pay for online visits by an in-network or out-of-network professional provider or an online vendor selected by BCBSM to:

- Diagnose a condition
- Make treatment and consultation recommendations
- Issue a prescription if appropriate
- Provide other medical or health treatment

NOTE

Online visits by an in-network provider or an online vendor selected by BCBSM are subject to the coinsurance and deductible requirements found in Section 2. Online visits by an out-of-network provider are subject to applicable out-of-network cost-sharing. Online visits by an online vendor not selected by BCBSM will not be covered.

Office, Outpatient and Home Medical Care Visits (continued)

Online Visits (continued)

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

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

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

Online visits do not include:

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

Oncology Clinical Trials

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

For general surgery services, see Page 118.

For transplant services, see Page 127.

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 antineoplastic drugs to treat stages II, III and IV breast cancer
- All stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial

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

Mandatory Preapproval

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

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

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

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

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

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

Oncology Clinical Trials (continued)

Mandatory Preapproval (continued)

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

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 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 hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient stay at a cancer center 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:

- Antineoplastic drugs. If Michigan law requires it, we cover these drugs and the reasonable cost of giving them.
- Immunizations. We pay for vaccines against infection during the first 24 months after a transplant as recommended by the 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”)
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor’s health care coverage will pay for such services
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn’s umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this certificate
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)

Oncology Clinical Trials (continued)

We do not pay for: (continued)

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

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

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

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

Optometrist Services

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

We pay for:

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

- 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.

Outpatient Diabetes Management Program

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

Locations: We pay for services provided in a 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

Outpatient Diabetes Management Program (continued)

We pay for (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.

NOTE

Syringes, insulin and prescription drug benefits are under a prescription drug benefit in this certificate (see Page 80).

Pain Management

For home infusion therapy services, see Page 44.

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

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

- A participating hospital (inpatient or outpatient)
- A 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 9 for what you may be required to pay for these services.

For autism disorders, see Page 20.
For chiropractic services and osteopathic manipulative therapy, see Page 26.
For physical therapy services provided in a home, see Page 42.
For occupational therapy services, see Page 61.
For speech-language pathology services, see Page 109.

Locations: We pay for 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 participating 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

- A member's home

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

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 21.

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

Physical Therapy (continued)

We pay for: (continued)

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

- **Occupational therapy**
- **Physical therapy**
- **All chiropractic manipulations** (rehabilitative only)
- **Osteopathic manipulative therapy** (rehabilitative only)

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will accumulate against the visit maximum.

If services in a member's home are billed by a home health care agency, they will not accumulate against the visit maximum.

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

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

- Physical therapy must be:
  - Prescribed by a professional provider licensed to prescribe it unless it is performed by a chiropractor (see page 27)
  - Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning.

Physical Therapy (continued)

Physical therapy must be: (continued)

– Given by the approved providers in the locations listed below:

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

We do not pay for:

- More than 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
- Services received from a nonparticipating hospital, freestanding outpatient physical therapy facility, skilled nursing facility, or any other facility independent of a hospital
- Services received from 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 billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate
- Therapy billed as an habilitative service when it does not meet the definition of habilitative service in this certificate
- Therapy that is performed without a physical therapy treatment plan 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

Physical Therapy (continued)

We do not pay for: (continued)

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

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

  - Part of a comprehensive rehabilitation plan, and
  - Medically necessary to treat severe deficits in 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 our prescription drug program, see further down in this section.

For chemotherapy services, see Page 26.

For contraceptive services, see Page 100.

Your coinsurances and copayments for prescription drugs is stated in the charts on pages 82 – 84*. You are required to fulfill your annual deductible, as stated in the "What You Must Pay" section, before prescription drug coinsurances or copayments apply. Deductibles, coinsurances and copayments combined comprise your annual out-of-pocket maximum.*

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

NOTE

The copayments listed in this section only apply to prescription drugs from a retail or mail-order pharmacy. They do not apply to the hospital pharmacy benefit. Please see Page 94.

We pay for:

Prescription Drugs Received from a Pharmacy

Locations: We pay for each covered drug and each refill of a covered drug as dispensed by a pharmacy subject to the following:

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

Your annual out-of-pocket maximum for covered services is described in the "What You Must Pay" section of this certificate. Most copayments or coinsurance for covered drugs are included in the annual out-of-pocket maximum. Once you reach the maximum, covered drugs will be reimbursed at 100 percent of the approved amount for the rest of the calendar year.

After the annual deductible requirement has been met, we will pay for each covered drug and each refill of a covered drug.

Prescription Drug Quantities
We pay up to a 30-day supply of a covered drug. We may make exceptions for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers).

NOTE

The 30-day supply limitation also 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; however, we may initially limit a supply of a specialty pharmaceutical to 15 days.

Prescriptions Drugs (continued)

We pay for: (continued)

Select Specialty Drugs and Controlled Substances

We reserve the right to:

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

Your cost-sharing 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.

**To see BCBSM's list of drugs that may have this limit, please go to bcbsm.com/pharmacy.*

Covered Drugs Obtained from an In-Network Pharmacy

We will pay an in-network pharmacy for your covered prescription drugs minus your cost-sharing. 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 the Essential Health Benefits benchmark plan. (Some drugs covered under the medical benefit are used to meet this standard.)

Mail Order Prescription Drugs

Drugs obtained from in-network mail-order providers are covered. Your copayment for a 31-60 day supply of covered drugs is twice the amount you would pay for a supply of 30 days or less. Your copayment for a 61-90 day supply of covered drugs is three times your 30 days copayment, minus $10.

Prescription Drugs 90-Day At Retail Network Supply

Drugs obtained from the 90-Day Retail Network are covered. Your copayment for an 84–90 day supply of covered drugs is three times your 30-day copayment, minus $10. A supply for a period of 31-83 days is not covered.

Prescription Drugs (continued)

We pay for: (continued)

Generic Drugs

Your copayment for covered generic drugs is as follows:

If a generic drug is prescribed 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 $10	You pay $10	You pay $10
31-60 days	BCBSM does not cover	You pay $20	BCBSM does not cover
61 – 83 days	BCBSM does not cover	You pay $20	BCBSM does not cover
84 – 90 days	You pay $20	You pay $20	BCBSM does not cover

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

Preferred Brand-Name Drugs

The chart below shows your copayment for a preferred brand name drug. The copayment is the same even if there is no generic equivalent available.

If a preferred brand name drug is prescribed 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 $40	You pay $40	You pay $40
31-60 days	BCBSM does not cover	You pay $80	BCBSM does not cover
61 – 83 days	BCBSM does not cover	You pay $110	BCBSM does not cover
84 – 90 days	You pay $110	You pay $110	BCBSM does not cover

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

Prescription Drugs (continued)

We pay for: (continued)

Non-Preferred Brand-Name Drugs

The chart below shows your copayment for a non-preferred brand name drug. The copayment is the same even if there is no generic equivalent available.

If a non-preferred brand name drug is prescribed 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 $80	You pay $80	You pay $80
31-60 days	BCBSM does not cover	You pay $160	BCBSM does not cover
61 – 83 days	BCBSM does not cover	You pay $230	BCBSM does not cover
84 – 90 days	You pay $230	You pay $230	BCBSM does not cover

Generic and Preferred Brand-Name Specialty Drugs

The chart below shows your copayment or coinsurance for each covered generic or preferred brand name specialty drug. These copayments and coinsurances are the same even if there is no generic equivalent available. The minimum coinsurance you pay will be 15 percent of the approved amount.

If a generic or preferred brand name specialty drug is prescribed 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% of the approved amount, but no more than $150	You pay 15% of the approved amount, but no more than $150	You pay 15% of the approved amount, but no more than $150
31-60 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover
61 – 83 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover
84 – 90 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover

Prescription Drugs (continued)

We pay for: (continued)

Non-Preferred Brand-Name Specialty Drugs

The chart below shows your copayment or coinsurance for each covered non-preferred brand name specialty drug. The copayment is the same even if there is no generic equivalent available. The minimum coinsurance you pay will be 25 percent of the approved amount.

If a nonpreferred brand name specialty drug is prescribed 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	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300
31-60 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover
61 – 83 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover
84 – 90 days	BCBSM does not cover	BCBSM does not cover	BCBSM does not cover

Prescription Drugs (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 prescriber, 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 prescriber requests prior authorization and shows that the drug meets BCBSM's prior authorization criteria
- We approve the request.

Once we receive all the information needed to make a decision, we will notify the prescriber whether a drug is authorized within:

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

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

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

If your prescriber prescribes certain brand-name drugs but then changes your prescription to a generic drug:

- Your copayment or coinsurance may be initially be waived for a period of time
- After this initial period of time, you must pay the generic copayment if a generic drug continues to be prescribed. If your plan requires a deductible, you must first pay it and then you must pay the generic copayment or coinsurance.

Prescription Drugs (continued)

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

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

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

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

Exclusions

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

NOTE

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

Prescription Drugs (continued)

Chemotherapy Specialty Pharmaceuticals

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

This prior authorization rule applies to all chemotherapy specialty drug claims, whether in Michigan or out of the state. Your prescriber 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 prescriber. In order to be approved, the drugs must:

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

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

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

Contraceptive Medication

We pay for FDA-approved generic contraceptive drugs. We are required to do so by the Patient Protection and Affordable Care Act (PPACA).

When a covered **generic** or select brand name contraceptive drug is dispensed by an in-network pharmacy, we will pay 100 percent of our approved amount. You have no out-of-pocket costs in these instances.

If you get an FDA-approved brand name contraceptive drug that is not on our list, you pay applicable cost-sharing.

You do not have to pay cost-sharing for brand name contraceptive drugs not on our list if your prescriber receives prior authorization from BCBSM.

To get prior authorization, your prescriber must show that the drugs are medically necessary and meet our conditions.

Prescription Drugs (continued)

Preventive Drugs, Immunization Vaccines, Supplements and Vitamins

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

- Preventive drugs
- Select immunization vaccines
- Supplements
- Vitamins

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

A prescription is required for most preventive drugs, immunization vaccines, supplements and vitamins and they must be:

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

NOTE Some services may not need a prescription. An example would be immunization vaccines you might receive in a pharmacy.

You pay no cost-sharing for covered generic or select brand name drugs if:

- They are preventive drugs, supplements or vitamins and
- You get them from a participating or in-network pharmacy

We will pay 100 percent of the approved amount when an in-network pharmacy fills a prescription for other brand name drugs. However, your prescriber must receive prior authorization from BCBSM before we will pay this amount.

Prior authorization will be decided based on:

- Medical necessity,
- The patient's current medical information, and
- Criteria approved by BCBSM

NOTE We may require you to try one or more preferred drugs before we will pay for the brand-name drug.

For a complete list of the federal government's current preventive health services, go to the https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Prescription Drugs (continued)

Requests for Drugs Not on BCBSM's Drug List

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

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

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

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

If we approve the exception request, you will have to pay your deductibles, coinsurances or copayments.

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

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

For Maximum Allowable Cost (MAC) Drugs
When you receive a generic MAC drug from an in-network pharmacy, you pay your cost-sharing as noted in your coverage.

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 book for the phone number or address of the customer service center nearest you. Or check our website at bcbsm.com.

Prescription Drugs (continued)

Covered Drugs Obtained from an Out-of-Network Pharmacy
If you receive covered drugs from an out-of-network pharmacy, you may have to pay additional cost-sharing. This is described in your benefit package.

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 book for the phone number or address of the customer service center nearest you. 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 or other cost share. If the drug is to treat an emergency, we will reimburse you 100 percent of 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 or other cost share.

For All Covered Drugs
If your prescriber prescribes certain brand-name drugs but then changes your prescription to a generic drug:

- Your copayment or coinsurance may be initially be waived for a period of time
- After this initial period of time, you must pay the generic copayment or coinsurance if a generic drug continues to be prescribed. If your plan requires a deductible, you must first pay it and then you must pay the generic copayment or coinsurance.

Prescription Drugs (continued)

Prescription Drugs Not Covered

- We will not pay for the following:
  - Contraceptives not required to be covered under the Patient Protection and Affordable Care Act.
  - 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.
  - Prescription drugs for the treatment of gender dysphoria that are considered by BCBSM to be cosmetic, or prescription drug treatment that is experimental or investigational.
  - 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
    - More than a 30-day supply of a covered drug or more than a 90-day supply of a covered drug obtained from a 90-day retail network provider or mail order drug. We may make exceptions for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

The 30-day supply limitation also 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.

  - Any drug we think is experimental or investigational. However, if Michigan law requires us to pay for the cost of an antineoplastic drug or the reasonable cost to administer the drug, we will pay for these costs.
  - Any covered drug entirely consumed at the time and place of the prescription
  - More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescriber 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.
  - Anything other than covered drugs
  - Diagnostic agents
  - Drugs that are not labeled “FDA approved," except insulin, or such drugs that BCBSM designates as covered

Prescription Drugs (continued)

Prescription Drugs Not Covered (continued)

- 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.) Some chemotherapeutic drugs may be subject to prior authorization review.
- Covered drugs dispensed to a member when such services are benefits under other Blue Cross and Blue Shield certificates
- Drugs obtained before the effective date of this contract, or after the contract ends
- Claims for covered drugs submitted after the applicable time limit for filing claims
- Support garments or other nonmedical items
- Compounded drugs that contain any bulk chemical powders or ingredients that are not approved by BCBSM
- Chemotherapy specialty pharmaceuticals that have not been preapproved.
- Brand-name drugs with a generic equivalent available (multi-source brand)
- Any vaccine given solely to resist infectious diseases (except for select immunization vaccines)
- State-controlled drugs
- Administration of covered drugs except for select immunization vaccines
- Non-self-administered injectable drugs (except for select immunization vaccines)
- OTC drugs unless deemed an essential health benefit are not considered a covered drug
- Prescription drugs with comparable OTC products available including, but not limited to, cough/cold medications
- Lifestyle drugs, such as but not limited to drugs used for weight loss or erectile dysfunction
- Compounded hormones
- Select high abuse drugs
- Dietary supplements
- 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
- Drugs newly approved by the FDA and not yet reviewed for coverage determination by BCBSM
- Drugs not recommended by the 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.

Prescription Drugs (continued)

Prescription Drugs Not Covered (continued)

- Elective Abortions – 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

Elective abortions do not include:

  - A prescription drug or device intended as a contraceptive;
  - Services, devices, drugs or other substances provided 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.

- Refills of prescriptions for covered drugs that exceed BCBSM's limits:

  - BCBSM does not cover refills that are dispensed before 75 percent of the time the prescription covers has elapsed.

  - You fill your prescription on March 1. The prescription can be refilled every 30 days. If you get a refill before March 23 (75% of 30 days), it will not be covered.
  - Your prescription can be refilled every 30 days, but your coverage requires the pharmacy to dispense two 15-day supplies. Your prescription is filled on March 1 and you are given a 15-day supply. If you get a refill before March 12 (75% of 15 days), it will not be covered.

  - BCBSM does not cover more refills than your prescription allows.

Your prescription can be refilled six times. If you get a seventh refill, it will not be covered.

Prescription Drugs (continued)

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

Drugs Received in Other Locations

- Drugs are also payable:
  - In a participating freestanding ambulatory surgery facility when directly related to surgery (see Page 120)
  - In a freestanding ESRD facility in conjunction with dialysis services (see Page 36)
  - In a participating skilled nursing facility (see Page 108)
  - As part of home health services when services are provided by a participating hospital (see Page 42)
  - When required for home infusion therapy (see Page 44)
  - In a hospice for the comfort of the patient (see Page 44)
  - In a participating residential substance abuse treatment facility or as part of an outpatient substance treatment program (see Page 55).

Prescription Drugs (continued)

- **Drugs Administered by a Physician**

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

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

    Specialty Pharmaceuticals: We pay for approved specialty drugs to be given to you by an in-network or participating provider. We pay for:

    - Drugs and their administration when ordered and billed by a physician, or
    - Drugs billed by the specialty pharmacy
    - Physician's administration of the drug

    NOTE Self-injected drugs are not covered.

  - **Hemophilia Medication**

    We will pay for hemophilia factor product when you get it from:

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

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

Prescription Drugs (continued)

- **Prior Authorization for Specialty Pharmaceuticals**

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

  - Office
  - Clinic
  - Home
  - Outpatient Facilities

  BCBSM requires prior authorization for specialty drugs for in-state and out-of-state services. Your physician should contact us and follow our utilization management processes to get prior authorization for your specialty drug. We will notify your physician if the request is approved. Only FDA-approved drugs can be preauthorized. Of those drugs, we will give preauthorization 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.

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

Preventive Care Services

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

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

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

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

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

We pay for:

- Preventive care services
- Related reading and interpretation of your test results

  But, if an in-network provider does a covered preventive test, and an out-of-network provider reads and interprets the results, we will pay the claim from the out-of-network provider as if it were an in-network claim. This means you will not have to pay your out-of-network cost-share.

  Cost-sharing is 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.

Preventive Care Services (continued)

We pay for: (continued)

- Flexible Sigmoidoscopy Examination

  One routine flexible sigmoidoscopy examination per member, per calendar year.

- Gynecological Examination

  One routine gynecological examination per member, per calendar year.

- Routine Pap Smear

  Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.

- Screening Mammography

  We pay for one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. You will not have to pay your cost-share if this service is done by an in-network provider. If the mammogram is done by an out-of-network provider, you will have to pay your out-of-network cost-share.

  NOTE

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

- Fecal Occult Blood Screening

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

- Well-Baby and Child Care Visits

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

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

Preventive Care Services (continued)

We pay for: (continued)

- Immunizations

  We pay for childhood 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 ordered by PPACA at the time the services are performed.

- Prostate Specific Antigen Screening

  We pay for one routine prostate specific antigen screening per member, per calendar year.

- Routine Laboratory and Radiology Services

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

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

- 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. It can be done by an in-network or an out-of-network provider.
  - If you have an in-network provider do the screening, you will not have to pay your cost-share.
  - If you have an out-of-network provider do the screening, you will have to pay your out-of-network cost-share.
  - If you need another colonoscopy done in the same calendar year, you will have to pay your cost-share. It can be done by an in-network or out-of-network provider.

Preventive Care 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 pay for screening, counseling and select prescription drugs to help you stop smoking.

- Women's Preventive Care Contraceptive Services

  - Voluntary Sterilization for Females

    We pay for hospital, facility, and physician's services for voluntary sterilizations for females. To see how much you will need to pay, see Page 14.

  - Contraceptive Counseling

    We pay for contraceptive counseling services provided to females during an annual physical or at a separate counseling session.

  - Contraceptive Devices

    We pay for a contraceptive device that needs a prescription by a physician, certified nurse midwife, or other legally authorized professional provider. We will also pay the provider to put in and take out a device.

  - Contraceptive Drugs

    See Page 87, "Contraceptive Drugs," for contraceptive medications that are payable as required by PPACA.

  - Contraceptive Injections

    We pay for injections given by a physician, certified nurse midwife, or other legally authorized professional provider. We also pay the provider for the injected medication if the provider supplies it. If a physician, certified nurse midwife, or other legally authorized professional provider injects you with a contraceptive medication you bought from a pharmacy, we only pay the provider for the injection.

  - Genetic Testing

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

Preventive Care 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 the https://www.healthcare.gov/coverage/preventive-care-benefits/ https://www.healthcare.gov/preventive-care-benefits/children website

  You may also contact BCBSM customer service.

Professional 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.

When you have a consultation appointment in an in-network physician's office, you will need to pay your copayment.

Prosthetic and Orthotic Devices

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

For durable medical equipment services, see Page 39.

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
- And permanently implanted in the body
- Or used externally, such as an artificial eye, leg or arm.

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

NOTE The definition of a physician includes an optometrist who is also a prosthetist, only when referring to prostheses for the eyes.

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

You may call us to confirm a provider's status.

Prosthetic and orthotic suppliers may include:

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

All suppliers must meet BCBSM qualification standards.

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
- Artificial eyes, ears, noses and larynxes

Prosthetic and Orthotic Devices (continued)

Provider Limitations (continued)

- Ostomy sets and accessories, catheterization equipment and urinary sets
- 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:

- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets.
- Hearing aids
- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hair pieces, hair implants, etc.

Radiology Services

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

For radiology services in an ambulatory surgical facility, see Page 120.

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

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

We pay for:

Diagnostic Radiology Services

- These services include facility and physician radiology services used to diagnose disease, illness, pregnancy or injury. The services must be prescribed by 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

Radiology Services (continued)

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; but preapproval is not required for radiology procedures that are:
      - Performed out-of-state
      - Performed in cases of emergency
      - Payable through Medicare because it is your primary coverage
    - The procedures for which preapproval was requested fall within BCBSM medical policy guidelines and
    - We approve the procedures
    - The procedures are performed in a participating facility. You or your physician may call us about the status of a specific facility.

  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.

  You may call us for information about any restrictions.

We do not pay for:

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

Therapeutic Radiology Services

We pay for physician's services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. 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 9 for what you may be required to pay for these services.

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

Requirements:

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

- The skilled nursing facility participates with BCBSM
- The admission is ordered by the patient's attending physician

We require 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 90 days per member, per calendar year.

We pay for:

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or bought from the skilled nursing facility
- Physician services (up to two visits per week)
- Physical therapy (Page 76), speech and language pathology services (Page 109) or occupational therapy (Page 61) when medically necessary

NOTE

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 maximums 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 use disorder
- Care for mental illness (other than for short-term nervous and mental conditions)
- Care provided by a nonparticipating skilled nursing facility

Special Medical Foods for Inborn Errors of Metabolism

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

We pay for:

Special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by a 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
600 E. Lafayette Blvd
Imaging & Support Services, MC 0010
Detroit, MI 48226-2998

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

For occupational therapy services, see Page 61.
For physical therapy services, see Page 76.

Special rules apply when speech and language pathology services are provided to treat autism (see Page 20).

Locations: We pay for facility and professional speech and language pathology services in the following locations subject to the conditions described below:

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

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 habilitative and 30 rehabilitative outpatient visits per member per year whether obtained from an in-network or out-of-network provider.

Speech and Language Pathology (continued)

We pay for: (continued)

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

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

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

NOTE

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

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

Speech and language pathology services must be:

- Prescribed by a professional provider licensed to prescribed speech and language pathology services.
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the 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.

Speech and Language Pathology (continued)

We do not pay for:

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

  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

- Therapy billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate

- Therapy billed as an habilitative service when it does not meet the definition of habilitative service in this certificate

- 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 that is performed without a speech and language pathology treatment plan that guides and helps monitor the provided therapy

- Services provided by speech-language pathology assistants or therapy aides.

- Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility

- More than 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year.

- 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 Use Disorder Treatment Services

See Page 13 in Section 2 for what you may be required to pay for these services.

For Mental Health services, please see Page 55.

For emergency services related to substance use disorder conditions, please see page 41.

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

- A participating inpatient hospital
- A participating outpatient setting
- A participating residential or outpatient substance abuse rehabilitation facility
- A participating outpatient psychiatric care (OPC) facility
- A physician's, fully licensed psychologist's, certified nurse practitioner's (CNP), clinical licensed masters social worker's (CLMSW), or licensed professional counselor's (LPC) office

All services are subject to the conditions described below.

Inpatient Hospital Substance Use Disorder Treatment Services

Services must be provided in a participating hospital.

We pay for:

- Acute detoxification

NOTE Acute detoxification is covered and paid as a medical service.

Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services

We pay for substance use disorder treatment in a:

- A participating residential substance abuse rehabilitation facility or
- A participating outpatient hospital
- A participating outpatient substance abuse rehabilitation facility.

Substance Use Disorder Treatment Services (continued)

Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services (continued)

The following criteria must be met.

- A physician must find that you need substance use disorder treatment and note in the medical record if the treatment should be residential or outpatient.
- A physician must:
  - Provide an initial physical exam
  - Diagnose the patient with a substance use disorder condition
  - Certify that the required treatment can be given in a residential or an outpatient substance abuse rehabilitation facility
  - Provide and supervise your care during subacute detoxification and
  - Provide follow-up care during rehabilitation
- The services need to be medically necessary to treat your condition.
- The services in a residential substance abuse rehabilitation facility must be preapproved by BCBSM.
- They must also be provided by a participating substance abuse treatment facility.

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

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

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

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

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

Substance Use Disorder Treatment Services (continued)

We do not pay for:

- 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
- Court ordered services
- Treatment, or supplies that do not meet BCBSM requirements

Outpatient Psychiatric Care Facility and Office Setting for Substance Use Disorder Services

We only pay for services in a **participating** outpatient psychiatric care (OPC) facility and office setting.

We pay for:

- Services provided by the facility's staff
- Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider as determined by BCBSM in an office setting or a participating outpatient psychiatric care facility:
  - Individual psychotherapeutic treatment
  - Family counseling for members of a patient's family
  - Group psychotherapeutic treatment
  - Psychological testing

  NOTE 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
- Prescribed drugs given by the facility in connection with treatment

Substance Use Disorder Treatment Services (continued)

Outpatient Psychiatric Care Facility and Office Setting for Substance Use Disorder Services (continued)

We do not pay for:

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

Surgery

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

For transplant services, see Page 127.

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

- A participating hospital (inpatient or 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 consultation will be paid if the surgery you plan to have is covered under this certificate and will be done in a covered location (see above).

- You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:
  - Second opinion — a consultation to confirm the need for surgery
  - Third opinion — allowed if the second opinion differs from the initial proposal for surgery
  - Nonsurgical opinion — given to determine your medical tolerance for the proposed surgery

Surgery

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the 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

Surgery (continued)

- Sterilization (whether or not medically necessary)

  NOTE

  As part of your preventive services, we cover voluntary sterilization for females (see Page 100).

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

- **Cosmetic surgery** is <u>only</u> payable when medically necessary:

  – Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  – Correction of deformities resulting from cancer surgery including reconstructive surgery after a mastectomy
  – Conditions caused by accidental injuries, and
  – Traumatic scars
  – Blepharoplasty of Upper Lids
  – Breast Reduction
  – Surgical Treatment of Male Gynecomastia
  – Panniculectomy
  – Sleep Apnea Treatments:

    - Rhinoplasty
    - Septorhinoplasty

  NOTE

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

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

  – Multiple extractions or removal of unerupted teeth or 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 32 for examples)

  – For surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ), see Page 33.

Surgery (continued)

We pay for: (continued)

- **Bariatric surgery** - one surgery during each member's lifetime.
- **Multiple surgeries** performed on the same day by the same physician are payable according to national standards recognized by BCBSM.
- **Technical surgical assistance (TSA**): In some cases, a surgeon will need another physician to give them technical assistance. We pay the approved amount for TSA, according to our guidelines. The surgery can be done in a:
  - Participating hospital (inpatient or outpatient)
  - Participating ambulatory surgery facility

  A list of TSA surgeries that we cover is available from your local customer service center.

  - 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
    - Services are provided in a location other than a hospital or ambulatory surgery facility

<u>Freestanding Ambulatory Surgery Facility Services</u>

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.

The following services are payable:

- Use of ambulatory surgery facility
- Anesthesia services and materials
- Recovery room
- Nursing care by, or under the supervision of, a registered nurse
- Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery

Surgery (continued)

Freestanding Ambulatory Surgery Facility Services (continued)

- Oxygen and other therapeutic gases
- Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissue, as well as the cost of processing and storage
- Administration of blood
- Routine laboratory services related to the surgery or a concurrent medical condition
- Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
- Housekeeping items and services
- EKGs

We do not pay for:

- Services by a nonparticipating ambulatory surgery facility

Temporary Benefits 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
Preapproval from BCBSM must be obtained before the services described in this certificate (except emergency or ambulance services) will be paid. If preapproval for the services is not obtained, 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 127.

NOTE

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, copayments, and coinsurances.

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 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 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 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 Section 2 beginning on page 9 for information about what cost-sharing you must pay for accidental injuries and emergency services.

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

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 or copayments.

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

Payable Services (continued)

- **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

- **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.

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

Payment will be subject to the following provisions: (continued)

Limitations and Exclusions

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

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

- Any other services, admissions or length of stay related to any of the above exclusions
- The 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 9 for what you may be required to pay for these services.

For general surgery services, see Page 118.

For oncology clinical trials, see Page 67.

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 131) **only** if they are done in a "designated facility". (See the definition of a designated facility on Page 176.)

We pay for:

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

Organ transplants

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

- 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.

Transplant Services (continued)

Bone Marrow Transplants

Bone marrow transplants require preapproval. If you do not get preapproval before you receive the transplant, neither it nor any related services will be covered and you will have to pay all costs.

When they are directly related to:

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

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

- Allogeneic Transplants
  - Blood tests on first degree relatives to evaluate them as donors
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
    - A first degree relative and matches at least four of the six important HLA genetic markers with the 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 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)

We pay for: (continued)

Bone Marrow Transplants (continued)

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

A tandem autologous transplant is covered only when it treats germ cell tumors of the testes 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 and autologous transplants are covered to treat only certain conditions. Please call Customer Services for a list of these conditions.**

Additional services for bone marrow transplants:

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

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

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

Transplant Services (continued)

We do not pay the following for bone marrow transplants:

- Services that are not medically necessary (see Section 7 for the definition of “medically necessary”)
- Services provided in a facility that does not participate with BCBSM
- Services provided by persons or groups that are not legally qualified or licensed to provide such services
- Services provided to a transplant recipient who is not a BCBSM member
- Services provided to a donor when the transplant recipient is not a BCBSM member
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- Expenses related to travel, meals and lodging for donor or recipient
- 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

Specified Human Organ Transplants require preapproval. If you do not get preapproval before you receive these services, it will not be covered and you will have to pay for it. However, once you get preapproval for the transplant, any services that you receive within one year from the date of the transplant will be covered as long as those services are medically necessary and related to the preapproved transplant.

When performed in a designated facility (see Section 7 “Definitions” on Page 176), **we pay for** transplant of the following organs:

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

Transplant Services (continued)

Specified Human Organ Transplants (continued)

When directly related to the transplant, we pay for:

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

NOTE

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

During the benefit period, the deductible and copayments do not apply to the specified human organ transplants and related procedures.

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:

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

Transplant Services (continued)

Specified Human Organ Transplants (continued)

Limitations and Exclusions (continued)

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

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

Value Based Programs

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

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

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

This section describes what we cover under PDCM.

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

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

We pay for:

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

PDCM services may include:

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

NOTE Covered services are subject to change.

Value Based Programs (continued)

We pay for (continued)

PDCM services may include: (continued)

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

Eligibility

You are eligible to receive PDCM services if you have:

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

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

- Diagnosis
- Admission status
- Clinical status

Termination of Provider- Delivered Care Management

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

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

We do not pay for:

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

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

Value Based Programs (continued)

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

This section describes what we cover under BDTC.

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

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

We pay for:

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

BDTC services may include:

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

NOTE Covered services are subject to change.

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

Value Based Programs (continued)

Blue Distinction Total Care (BDTC) (continued)

Eligibility

You are eligible to receive BDTC services if you have:

- Active BCBSM coverage

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

- Diagnosis
- Admission status
- Clinical status

Termination of Blue Distinction Total Care

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

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

We do not pay for:

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

For more information on BDTC services, contact BCBSM customer service.

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, other facilities, 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 plus cost sharing, if any, as payment in full for covered services. 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. If 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. Before you make an appointment with an out-of-network provider, you will need to find out if they are a participating or a nonparticipating provider with BCBSM. *Here's why:* • **Participating providers** —BCBSM will send the payment directly to the participating providers. They will accept the payment of BCBSM's approved amount as payment in full. • **Nonparticipating physicians and other professional providers** —BCBSM will send the payment directly to you. You will need to pay the physician. • **Nonparticipating hospitals --** 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. • **Nonparticipating other facilities and alternative to hospital care providers*** -- BCBSM will not pay for services from nonparticipating facilities and alternative to hospital care providers.

* 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) National Account Arrangements
- Blue Cross Blue Shield Global Core 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 (for drugs only)
- 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 Other Facilities	BCBSM's approved amount minus what you must pay	Provider*	In-Network • Deductible • Coinsurance • Copayments (for drugs only) (See Section 2)	Provider
		NON-COVERED SERVICES			
		You may be billed for:		**You may NOT be billed for:**	
		• Services not covered by your contract • Services that BCBSM has determined are not medically necessary or are experimental • You may be billed only if: – You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary, or it is experimental and you agree to pay for the service – The provider gives you an estimate of what the services will cost you • 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 • An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM* • Balances that are more than the approved amounts	

***** If you need to know what providers are paid directly, call us at one of the numbers listed in Section 9: "How to Reach Us".

** BCBSM may deny a claim from a participating provider that was sent in more than two years 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 Other Facilities**	BCBSM's approved amount minus what you must pay	Provider	Out-of-Network (see Section 2) • Deductible • Coinsurance • Copayments (for drugs only Out-of-network deductibles, coinsurances and copayments are not applied to: • 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 • Services from a provider for which there is no PPO network • 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

You may not need to pay your out-of-network deductible, copayment, or coinsurance for select services 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.

- Your screening mammography is performed by an in-network provider but an out-of-network provider does the analysis and interprets the results

Even though you do not have to pay for the out-of-network cost-sharing for these services, 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".

Out-of-Network Providers (continued)

Out-of-Network Participating Providers (continued)

If you receive services from an out-of-network provider, the amount you pay will depend on the provider's status. The following pages explain what you must pay for services of out-of-network providers.

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 Other Facilities**	• Services not covered by your contract • Services that BCBSM has determined are not medically necessary or are experimental. You may be billed only if: – You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary or it is experimental and you agree to pay for the service – The provider gives you an estimate of what the services will cost you • 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 • An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM • A balance in excess of our approved amount

* BCBSM may deny a claim from a participating provider that was sent in more than two years 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.

Out-of-Network Nonparticipating Providers

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 • Deductible • Coinsurance • Copayments (for drugs only) AND The difference between BCBSM's approved amount and the amount charged by the nonparticipating provider (this amount is not applied toward your cost-sharing requirements)	Provider
	Hospital and Other Facilities	• Coverage is limited to treatment of an accidental injury or medical emergency BCBSM's payment for these services is limited (see Page122)	Member	In-Network • Deductible • Coinsurance • Copayments (for drugs only) AND The difference between BCBSM's approved amount and the amount charged by the nonparticipating provider (this amount is not applied toward your cost-sharing requirements)	Provider

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.

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

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

* Some nonparticipating professional providers **may** agree to participate 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.

Out-of-Network Nonparticipating Providers (continued)

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

Nonparticipating Hospitals, Facilities and Alternative to Hospital Care Providers

BCBSM does not pay for services at nonparticipating:

- Hospitals
- Outpatient physical therapy facilities
- Outpatient Psychiatric Care Facilities
- Substance Abuse Rehabilitation Facilities
- Psychiatric Residential Treatment Facilities
- Freestanding ambulatory surgery facilities
- Freestanding ESRD facilities
- Home health care agencies
- Hospice programs
- Long-term Acute Care Hospitals
- Skilled nursing facilities, or
- Ambulatory infusion centers.

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

BlueCard® PPO Program

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

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

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

BlueCard PPO Network Providers

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

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

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

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

- The billed charges for your covered services; or
- The negotiated price that the Host Plan makes available to us.

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

- A simple discount that reflects an actual price that the Host Plan pays to your provider.
- An estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges.
- An average price based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

BlueCard PPO Program (continued)

The Host Plan will determine what pricing it will use. The Host Plan can negotiate with the provider to determine the price for each service. However, under the terms of the BlueCard Program, the price the Host Plan uses will be the final price that you are responsible for. There will be no pricing adjustment once that price has been determined.

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.

BCBSM may process claims for covered services through a negotiated account arrangement with one or more Host Plans as an alternative to BlueCard. In those instances, the negotiated terms will determine the payment amount. Your cost share will be calculated based on the negotiated priced or the lower of either the billed amount or the negotiated price.

We have included a factor for bulk distributions from Host Plans in your premium for Value-Based Programs when applicable under this agreement.

If your coverage contains reference-based benefits, special rules apply. Reference-based benefits are those that have dollar limits for specific procedures. These limits are based on a Host Plan's local market rates. You will be responsible for paying the amount the provider bills above the specific reference benefit limit for a given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, you will incur no additional liability, other than any applicable cost sharing required in your certificate or riders.

BlueCard PPO Out-of-Network Providers

If the provider is not a Host Plan PPO network provider and does not participate with the Host Plan, we will only pay our out-of-network provider amount, and you will be responsible for the difference, unless:

- 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.

BlueCard PPO Program (continued)

Nonparticipating Providers Outside Our Service Area

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

- Call your customer service representative at one of the numbers listed in Section 9: "How to Reach Us" for information on filing claims.
- Submit an itemized statement to us for the services.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider. (We do not pay for services of nonparticipating facility providers listed on Page 145 and provide very limited coverage for services of nonparticipating hospitals.)

In all cases, you are also responsible for the out-of-network deductible, copayment and/or coinsurance required under 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 for a listing of participating providers.

Member Liability Calculation

When you receive covered services outside of our service area from nonparticipating providers, the amount you pay for these services will generally be based on either:

- What the Host Plan pays its nonparticipating providers or
- The price required by applicable state or federal law

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount that BCBSM paid for the service.

Exceptions:

In some situations, we may use other payment methods to determine the amount we will pay for services rendered by nonparticipating providers.

These methods may include:

- Billed covered charges
- The payment we would make if the services were provided in our service area
- A special negotiated payment

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount we will pay for the covered services.

BlueCard PPO Program (continued)

Specialty Providers in the BlueCard Program

The Host Plan can pay for you to get medical care from providers who offer special services (e.g., allergist, chiropractor, 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
- This certificate excludes coverage for services performed outside of Michigan
- The provider specialty is not covered by BCBSM or the Host Plan.
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program or
- The services are performed by a vendor or provider who does not have a contract with BCBSM for those services.

Negotiated (non-BlueCard Program) 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

Blue Cross Blue Shield Global Core Program

If you are living or traveling outside of the United States, the Blue Cross Blue Shield Global Core Program will assist you in getting covered health care services. This program provides access to a worldwide network of inpatient, outpatient and professional providers and it also includes claims support services.

The Blue Cross Blue Shield Global Core Program is different from the BlueCard PPO Program in certain ways. For example, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of health care providers, the network does not have Host Plans.

A PPO network is not available outside the United States.

In this section, references to participating or nonparticipating providers mean they participate or do not participate in the Blue Cross Blue Shield Global Core Program.

Medical Assistance Services
If you need medical services while traveling or living outside of the United States, contact the Blue Cross Blue Shield Global Core Service Center at:

- 1-800-810-BLUE (2583) or
- Call 804-673-1177 collect, if you are calling from outside the United States

The center's staff will help you get the information about participating hospitals, physicians and medical assistance services. If you do not contact the Blue Cross Blue Shield Global Core Service Center, you may have to pay for all of the services that you receive.

Coverage for Blue Cross Blue Shield Global Core Participating Hospitals
Inpatient Hospital Services

- If you need to be admitted to a hospital as an inpatient, call the Blue Cross Blue Shield Global Core Service Center to arrange for cashless access with a participating hospital. Cashless access means that you will only have to pay the in-network deductible(s) and copayment(s) for all covered services when you are admitted to the hospital. The hospital will file the claim with the Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.

Blue Cross Blue Shield Global Core Program (continued)

Coverage for Blue Cross Blue Shield Global Core Participating Hospitals (continued)

Outpatient Hospital Services

- You are responsible for:
  - Paying for all of the outpatient services at the time they are provided
  - Submitting the international claim form(s)
    - Forms are available from BCBSM, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.
  - Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Coverage for Blue Cross Blue Shield Global Core Nonparticipating Hospitals

Inpatient Hospital Services

- If you need to be admitted to a nonparticipating hospital as an inpatient, call the Blue Cross Blue Shield Global Core Service Center to get a referral for cashless access. Cashless access means that you will only have to pay the out-of-network deductible(s) and copayment(s) for all covered services you receive when you are admitted to the hospital. The hospital will file the claim with the Blue Cross Blue Shield Global Core Service Center for you.

- You are responsible for:
  - Out-of-network deductible(s), copayment(s) and coinsurances
  - The payment of noncovered services
  - If you set up cashless access, you will be responsible for the out-of-network deductible(s) and copayment(s) and non-covered services.
  - If you do not contact the Blue Cross Blue Shield Global Core Program 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 Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.
  - Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.

Blue Cross Blue Shield Global Core Program (continued)

Coverage for Blue Cross Blue Shield Global Core Nonparticipating Hospitals (continued)

Outpatient Hospital Services

- You are responsible for:
  - Paying for all outpatient services at the time they are provided
  - Submitting the international claim form(s)
    - Forms are available from BCBSM, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.
  - Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Emergency Services at Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.
- You must provide copies of your medical record, the itemized bill, and proof of payment along with the claim form. BCBSM will only pay for covered services.

Blue Cross Blue Shield Global Core Professional Services

- You are responsible for payment of all professional services at the time they are provided.
- You are also responsible for submitting the international claim form(s).
  - Forms are available from BCBSM, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.
- You must provide copies of your medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 5: General Services We Do Not Pay For

The services listed in this section are in addition to all other **nonpayable** services stated in this certificate.

We do not pay for

- Noncontractual services that are described in your case management treatment plan, if the services have not been approved by BCBSM.

- Gender reassignment services, including prescription drug treatments, that BCBSM considers to be cosmetic, or treatment that is experimental or investigational.

- Elective Abortions – 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 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

- Radial keratotomy surgery

- Private duty nursing services

- Court ordered services

We do not pay for: (continued)

- Hospitals admissions for services that are not acute, such as:
  - Basal metabolism tests
  - Cobalt or ultrasound studies
  - Convalescence or rest care
  - Convenience items
  - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
  - Diagnostic evaluations
  - Electrocardiography
  - Lab exams
  - Observation
  - Weight reduction
  - X-ray, exams or therapy
  - Those mainly for physical therapy, speech and language pathology services or occupational therapy
- Hospital services that we do not pay for:
  - Services that may be medically necessary but can be provided safely in an outpatient or office location
  - Custodial care or rest therapy
  - Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
  - Outpatient inhalation therapy
  - Sports medicine, patient education or home exercise programs
  - Services, care, supplies or devices related to an elective abortion
- Alternative 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, care, supplies or devices not prescribed by a physician
  - Services, care, supplies or devices related to an elective abortion
  - 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 119
  - Weight loss programs (unless covered elsewhere in this certificate or otherwise required by law)
  - Services provided during nonemergency medical transport
  - Experimental treatment
  - Hearing aids or services to examine, prepare, fit or obtain hearing aids
  - Prescription drug compounding kits or services provided to you related to the kits
  - Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged. Providers who are not legally authorized or licensed to order or provide such services.

If a participating BCBSM PPO in-network provider has not been credentialed or privileged by BCBSM to perform a service, they will be financially responsible for the entire cost of the service. They cannot bill you for their services. They also cannot bill you for any deductibles, copayments, or coinsurance amounts.

If you decide to get medical services from a nonparticipating out-of-network provider, who is not credentialed or privileged to perform those services, you will have to pay for the entire cost of the service.

  - Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
  - 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.

Section 6: General Conditions of Your Contract

This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.

Assignment

Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us, to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this certificate.

Changes in Your Address

Your employer or group must notify us of any changes in your address. An enrollment/change of status form should be completed when you change your address.

Changes in Your Family

Your employer or group must notify us of any changes in your family. Before this can occur, you must complete an enrollment/change of status form and give it to your employer or group. We must receive notice from your employer or group within 30 days of when a dependent or spouse is removed from your coverage and within 31 days of when a dependent or spouse is added. Any coverage changes take effect on the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Coordination of Benefits

We coordinate benefits payable under this certificate per Michigan's Coordination of Benefits Act.

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 prescriber proves that the drug or device is recognized for treatment of the condition it is prescribed for by:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE Chemotherapeutic drugs are not subject to this general condition.

The prescriber's documentation must show why all other contraceptives on the member's benefits are not an option for the member.

Deductibles, Copayments and Coinsurances Paid Under Other Certificates

We do not pay any cost sharing you must pay under any other certificate. An exception is when we must pay them under coordination of benefits requirements.

Enforceability of Various Provisions

Failure of BCBSM to enforce any of the provisions contained in this contract will not be considered a waiver of those provisions.

Entire Contract; Changes

This certificate, including your riders if any, is the entire contract of your coverage. No change to this certificate is valid until approved by a BCBSM executive officer. No agent has authority to change this certificate or to waive any of its provisions.

Experimental Treatment

Services That Are Not Payable

We do not pay for:

- Experimental treatment. This includes experimental drugs and devices
- Services 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.

This certificate does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

Experimental Treatment (continued)

How BCBSM Determines If a Treatment Is Experimental

If a treatment is not covered under Section 3, 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
- There is a written informed consent used by the treating provider in which the service is referred to as experimental or investigational or other than conventional or standard treatment.
- 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

When available, these sources are considered in deciding if a treatment is experimental under the above criteria: (continued)

- 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.

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.

NOTE This certificate does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This 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.

Fraud, Waste, and Abuse

We do not pay for the following:

- Services that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;
- Services that are performed by a provider who is sanctioned at the time the service is performed.

NOTE Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we will not process claims from that provider.

Genetic Testing

We will not:

- Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
- 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

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.

Guaranteed Renewability

Coverage under this certificate is guaranteed renewable.

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

Notification

When we need to send you a notice, we mail it to your employer or your remitting agent. This fulfills our obligation to notify you.

Payment of Covered Services

The services covered under this certificate may be combined and paid according to BCBSM's payment policies. Examples include multiple surgeries or a series of lab tests.

Personal Costs

We will not pay for:

- Transportation and travel, even if 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.

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.

Preapproval

Some medical benefits services require preapproval before you receive them. If you receive those services without first obtaining preapproval or prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the preapproval before you receive these medical services.

Prior Authorization

Some prescription drug services require prior authorization before you receive them. If you receive those services without first obtaining prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these services.

Release of Information

You agree to let providers release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

If we tell you a member is eligible for coverage or benefits are available, this does not guarantee 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, for which a member is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results
- Are not listed in this certificate as being payable

Subrogation: When Others are Responsible for Illness or Injury

If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury,

Then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is BCBSM's right of recovery. BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

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

- You
- Your covered dependents

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.

Subrogation: When Others are Responsible for Illness or Injury (continued)

BCBSM may:

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM's right of recovery.
- Request you to sign a reimbursement agreement.
- Delay processing of your claims until you provide a signed copy of the reimbursement agreement.
- Offset future benefits to enforce BCBSM's right of recovery.

BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made.

  Examples where BCBSM may utilize the subrogation rule listed below:

  BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:

  - When a third party injures you, for example, through medical malpractice;
  - When you are injured on premises owned by a third party; or
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to Medical reimbursement coverage

Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Termination of Coverage

You must provide the required notification if you want to terminate your coverage under this certificate.

Send your written request to terminate coverage to your employer. Your employer must notify BCBSM within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate will end**.**

Time Limit for Filing Pay-Provider Medical Claims

These claims are professional and facility claims for medical services. They do not include claims for prescription drugs received from pharmacies or for dental or vision services that are not covered under this certificate.

For participating provider claims:

- We will not pay medical claims filed after the timeframe set out in your treating provider's participation agreement with BCBSM.

For nonparticipating provider claims:

- For nonparticipating providers, the claims must be submitted within 24 months from the date of service.

Time Limit for Filing Pay-Subscriber Medical Claims

These claims are professional and facility claims for medical services. They do not include claims for prescription drugs received from pharmacies or for dental or vision services that are not covered under this certificate.

The time limit for filing claims is 24 months from the date of service. We will not pay claims filed after that date.

Time Limit for Filing Prescription Drug Claims

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

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

Time Limit for Legal Action

You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this certificate, before you begin legal action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

Unlicensed and Unauthorized Providers

We do not pay services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM), or
- Legally authorized or licensed to order or provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

Workers Compensation

We do not pay for treatment of work-related injuries covered by workers compensation laws. We do not pay for work-related services you get at an employer's medical clinic or other facility.

Section 7: Definitions

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Accidental Injury
Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Accredited Hospital
A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities. (Also see the definition of “Hospital" in this section.)

Acute Care
Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Acute Care Facility
A facility that provides acute care. This facility primarily treats 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 those with substance use disorder
- Skilled nursing or other nursing care

Administrative Costs
Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

Affiliate Cancer Center
A 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. Coinsurances and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

For prescription drugs: The lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug. The drug cost, dispensing fee and incentive fee are set according to our contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before we make our payment.

Approved Clinical Trial
Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the 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 for Autism
Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

- Are provided or supervised by a 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.

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 Cross Blue Shield Global Core Program
A program that provides access to an in-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 Distinction Total Care (BDTC)
A program that allows you to receive care management services outside the state of Michigan from a trained clinical care provider in a team effort with, and directed by, your primary care physician.

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.

NOTE

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.

Case Management
A program that is designed to help manage the health care of members with acute or chronic conditions. It is up to BCBSM to decide whether you qualify for this program.

In certain circumstances, BCBSM may find it necessary to pay for services that are generally not covered by your contract but that are medically necessary to treat your condition. When this occurs, a case management contract must be signed by you (or your representative), your provider and the BCBSM case manager. This contract will define the services that will be covered under the case management program.

If BCBSM has contracted with a vendor to manage the case management program, then that vendor will make decisions regarding case management and sign any necessary case management documents on behalf of BCBSM.

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

Certified Nurse Midwife
A nurse who provides some maternity, contraceptive, and other services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing

Certified Nurse Practitioner
A nurse who provides some medical and/or psychiatric services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist
A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Chronic Condition
A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the 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, clinical trials include:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance
A portion of the approved amount that you must pay for a covered drug or service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment, or recovery. 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.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends,
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event.

If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

Contraceptive Medication
A medication intended to prevent pregnancy.

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 an audit, adjustment, or recovery. 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 Drug
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.

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

Custodial Care
Care primarily used in helping the 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. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery. For prescription drugs, your deductible is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

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.

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

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

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

Dual Entitlement
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment
Equipment that can withstand repeated use and that is used for a medical purpose by a 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
The intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman.

Eligibility
As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

Emergency Care
Care to treat an accidental injury or medical emergency.

Emergency Medical Condition
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
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, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)
The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

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 Circumstance
An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on our approved drug list.

Experimental Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

Facility
A hospital or facility that offers acute care or specialized treatment, including, but not limited to, substance use disorder treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

First Degree Relative
An immediate family member who is directly related to the 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.

Food and Drug Administration (FDA)
An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Freestanding Outpatient Physical Therapy Facility
An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

Gender Dysphoria
A broad diagnosis that covers a person's emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gender Reassignment Services
A collection of drugs and services that are used to treat gender dysphoria. They may include hormone treatment and/or gender reassignment surgery, as well as counseling and psychiatric services. They must be medically necessary to be payable by BCBSM. BCBSM will not pay for drugs or services that it considers to be cosmetic. BCBSM will also not pay for drugs or services that are experimental or investigational.

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 the brand name drug.

Group
A collection of members under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination
A history and physical examination of the female genital tract.

Habilitative/Habilitation Services
Health care services that help you keep, learn, or improve skills and functioning for daily living.

Hazardous Medical Condition
The dangerous state of health of a 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.

NOTE

A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or those with substance use disorder
- Skilled nursing facilities or other nursing care facilities

Hospital privileges
Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

Host 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.

Impotence Drugs
Drugs that improve sexual potency.

In-Network Mail-Order Provider
A provider selected by BCBSM to provide covered drugs through our PPO program. In-network mail-order providers have agreed to accept the approved amount as payment in full for the covered drugs provided to members enrolled in our PPO mail-order program.

In-network Pharmacy
A pharmacy selected by BCBSM to provide covered drugs through our PPO program. In-network pharmacies have agreed to accept BCBSM's approved amount as payment in full for covered drugs 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 but not limited to those that treat erectile dysfunction or help a person lose weight.

Lobar Lung
A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital
A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

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

Mammogram
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.

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 (MAC)
The most BCBSM will pay for certain generically equivalent drugs covered by BCBSM.

Maximum Payment Level
The most BCBSM will pay for a covered service. For participating or in-network providers, it is the amount BCBSM pays the provider under the provider's contract with BCBSM. For services provided by nonparticipating or out-of-network providers, it is the amount BCBSM pays for the service to its participating or in-network providers or the amount BCBSM negotiates with the nonparticipating or out-of-network provider. Maximum payment level is not a "Medicare-like rate" described in 42 C.F.R. §136.30, et. seq.

Medical Emergency
A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury. Emergency services treat medical emergencies.

Medical Evidence Report
A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

Medically Necessary
A service must be medically necessary to be covered. There are two definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons) and other providers; another applies to hospitals and LTACHs.

- Medical necessity for payment of professional provider and other providers services:

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

  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and
  - Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

  NOTE

  "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

- Medical necessity for payment of hospital and LTACH services:

  Determination by BCBSM that allows for the payment of covered hospital services when <u>all</u> 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 Drug
A drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the 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.

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

Member
Any person eligible for 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.

Multiple Source Brand (MSB) Drug
A brand-name drug that has a generic equivalent available.

Network Providers
Also called "in-network providers" See the definition of "In-network Providers" on Page 183.

Newborn Care
Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the mother's attending physician.

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.

Non-participating Mail-Order Provider
A provider who does not have an agreement with BCBSM to provide covered drugs through the Mail-Order Prescription Drug Program. Nonparticipating 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.

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.

Non-Preferred Brand-Name Drug
A non-preferred 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.

Online Visit
A structured online health consultation using secure audio-visual technology to connect a professional provider in one location to a member in another location for the purpose of diagnosing and providing medical or other health treatment.

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 pharmacy 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 BCBSM's 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 those with substance use disorder.

Over-the-Counter (OTC) Drug
A drug that does not require a prescription under federal law.

Pap Smear
A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Hospitalization Program (PHP)
Treatment for mental or emotional disorders provided by a hospital or OPC to a patient who lives at home and goes to a hospital or OPC.

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 Mail-Order Provider
A provider who has an agreement with BCBSM to provide covered drugs through the Mail-Order Prescription Drug Program. Participating mail-order providers have agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

Participating PPO Provider
A provider who participates with the Host Plan's PPO.

Participating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before we make our payment.

Patient
The subscriber or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

Pay-Provider Claim
This is a type of claim where Blue Cross pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where Blue Cross will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Per Claim Participation
Available to some nonparticipating providers when they elect to accept 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.

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).

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

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 retain, learn, restore or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility

Physician
A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners." The term physician or practitioner may also include other types of professional providers when they perform covered services within their scope of practice.

Physician Assistant
A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-service Grievance
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

Practitioner
A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, 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.

Preapproval
A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained **before** you receive certain services described in this certificate, they will not be covered.

Preapproval 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.

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.

Pre-service Grievance
A pre-service grievance is an appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

Prescriber
A health care professional authorized by law to prescribe FDA-approved or state-approved 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 Care Physician (PCP)
The physician you choose to provide or coordinate all of your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

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

Primary Plan
The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

Professional Provider
One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Clinical licensed master's social worker (CLMSW)
- Licensed professional counselor (LPC)
- Oral surgeon
- Board certified behavior analyst
- Independent physical therapist (IPT)
- Independent speech therapist (IST)
- Independent Occupational therapist (IOT)
- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device
An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Protocol
A detailed plan of a medical experiment or treatment.

Provider
A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care or a pharmacy legally licensed to dispense drugs.

Provider-Delivered Care Management (PDCM)
A program that allows you to receive care management services in Michigan from a trained clinical care manager in a team effort with, and directed by, your primary care physician.

Psychiatric Residential Treatment Facility
A facility that provides residents with 24-hour mental 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 Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualified Individual
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 you to enroll in different health care coverage, change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment, other than for gross misconduct, or reduction of hours
  - Start of Military Service. Members must perform military duty for more than 30 days.
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

NOTE

The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Radiology Services
These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Referral
The process in which the PCP sends a patient to another provider for a specified service or treatment plan.

Refractory Patient
An individual who does not achieve clinical disappearance of the disease after standard therapy.

Registered Provider
A participating or nonparticipating provider (or in-network or out-of-network PPO provider) that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Rehabilitative/Rehabilitation Services
Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Relapse
When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the 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 on a residential basis specifically for those with substance use disorder 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.

Retail Health Clinic
A medical clinic located inside a retail store. It offers "walk-in" care for minor conditions, provided by a professional provider.

Reversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is **not** intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:
  - Arthrocentesis
  - Physical therapy (see Page 76 for physical therapy services)
  - Reversible appliance therapy (mandibular orthotic repositioning)

Rider
A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Routine Patient Costs
All items and services related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the 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 Over-the-Counter Drugs
Over-the-counter drugs identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

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 prescription drugs do not include antineoplastic drugs or drugs needed to treat an immediate life-threatening condition.

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.

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

Skilled Care
A level of care that can be given only by a licensed nurse to ensure the medical safety of the 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.

Specialist
A provider with a specific skill or expertise in the treatment of a particular condition or disease. The patient is referred to a specialist by his or her PCP.

Specialty Hospitals
Hospitals that treat specific diseases, such as mental illness.

Specialty Pharmaceuticals
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. **Select specialty pharmaceuticals require prior authorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by home infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy
Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech 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 and meets the group's eligibility requirements.

Stabilize
Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

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

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

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 Treatment Program Services
Subacute services to restore a person's mental and physical well-being when the person has a substance use disorder. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Substance Use Disorder
Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance use disorder is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases."

Tobacco addictions are included in this definition.

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 professional providers' 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 Need to Know

We want you to be satisfied with how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number is on the back of your 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 that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for a service, or

You may file a grievance or appeal about any adverse benefit decision within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in our review
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the customer service number on the back of your 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 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to BCBSM's decision to deny, reduce, terminate or cancel your coverage.

Grievance and Appeal Process (continued)

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

NOTE

You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
  - Our failure to comply must be for more than minor violations of the internal grievance process.
  - Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

Step 1: You or your authorized representative send us a written statement explaining why you disagree with our decision.

Mail your written grievance to:
Appeals Unit
Blue Cross Blue Shield of Michigan
600 East Lafayette Blvd.
M.C. CS3A
Detroit, MI 48226

Step 2: We will contact you to schedule a conference once we receive your grievance. During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at our office in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

Step 3: If you disagree with our final decision, or you do not receive our decision within 60 days after we got your original grievance, you may request an external review. See below for how to request an external review.

Grievance and Appeal Process (continued)

Standard External Review Process

Once you have exhausted our standard internal review process, you or your authorized representative may request an external review.

The standard external review process is as follows:

Within 120 days of the date you receive or should have received our final decision, send a written request for an external review to the Department listed below. Mail your request and the required forms that we give you to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

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.

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

Reviews of Medical Issues

Step 1: The Department will assign an independent review organization to review your request if it concerns a medical issue that is appropriate for an external review.

- You can give the Department additional information within seven days of requesting an external review. We must give the independent review organization all of the information we considered when we made a final decision, within seven days of getting notice of your request from the Department.

Step 2: The review organization will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Grievance and Appeal Process (continued)

Reviews of Nonmedical Issues

Step 1: If your request for review involves nonmedical issues and is appropriate for external review, the Department staff will conduct the external review.

Step 2: They will recommend if the Department should uphold or reverse our decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

- Your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

Expedited Internal Review Process

- The process to submit an expedited internal review is as follows:

Step 1: Call 313-225-6800 to request an expedited review. Your physician should also call this number to verify that you qualify for an expedited review.

Step 2: We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

Step 3: If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review.

Grievance and Appeal Process (continued)

Expedited External Review Process

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process is as follows:

Step 1: A request for external review form will be sent to you or your representative with our final adverse determination

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

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

Step 3: The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review organization to conduct the review. The organization will recommend within 36 hours if the Department should uphold or reverse our decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

Your plan may require preapproval of certain health services. If pre-approval is denied, you can appeal this decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the customer service number on the back of your 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 approved.

Pre-Service Appeals (continued)

Requesting a Standard Pre-Service Review

You may make the request yourself, or your professional provider or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your 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 and group numbers, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name, if different from your name
- A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Pre-Service Review

If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous 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 information details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the customer service number on the back of your Blues ID card.

Pre-Service Appeals (continued)

Other resources to help you

For questions about your rights, this certificate, or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Directory of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 1-877-999-6442; or

- Mail to:

  Department of Insurance and Financial Services
  P.O. Box 30220
  Lansing, MI 48909-7720

We Speak Your Language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܝܕ ܟܬܝܒܘܬܐ، ܐܢ ܠܐ ܦܬܝ ܦܩܝ ܡܬܝܠܘܬܐ ، ܡܫܡܫ ܠܗ ܟܬܝܒܘܬܐ، ܟܬܝܒܘܬܐ ܕܒܠܚܐ ܡܬܝܠܘܬܐ ܕܦܚܠܒܘܬܐ ܟܬܝܒܘܬܐ
ܕܠܩܬܘܚܐ ܕܠܟ ܠܒܬܟ. ܠܡܡܠܠܘܬܐ ܥܡ ܠܐܢ ܡܠܦܢܐ، ܡܨܐ ܥܠ ܠܒܠܒܟ ܡܢܬܟ ܡܠܦܢܐ ܕܠܩܘܚܬܟ ܐܢ ܠܐ ܡܫܬܡܫܢܐ ܐܢܬ
877-469-2583 TTY:711 ܝܕ ܡܠܦܢܐ ܕܠܠܒܟ ܡܢܬܟ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important Disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

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

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Area code 248, 313, 586, 734, 810 or 947
Southeast Michigan toll-free 1-877-790-2583

Area code 231, 269 or 616
West Michigan toll-free.....1-800-972-9797

Area code 517 or 989
Central Michigan toll-free 1-800-258-8000

Area code 906
Upper Peninsula toll-free.....1-800-562-7884

For when you are out-of-state, call BlueCard 800-810-2583

For when you are out of the country, call Blue Cross Blue Shield Global Core Program
.....804-763-1177 (call collect)

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit our website at bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit
600 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine

Flint
4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids
86 Monroe Center N.W., Grand Rapids 49503

Holland
151 Central Ave., Holland, 49423

To Visit (continued)

Lansing
232 S. Capitol Ave., Lansing 48933

Marquette
415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage
950 Trade Centre Way, Portage 49024

Traverse City
City Centre Plaza
202 State St., Traverse City 49686

Utica
6100 Auburn Road, Utica 48317
Diagonally across from the AAA building

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