Member Handbook
for Active Employees/COBRA of County of Oakland

Preferred Provider Organization (PPO)

Including:
Prescription Drugs
Hearing

BLUE CROSS BLUE SHIELD
CUSTOMER SERVICE DIRECTORY

We are committed to providing you with excellent customer service. When you have a question or need help, you can call a knowledgeable customer service representative or go to one of the websites listed below.

Blue Cross Blue Shield of Michigan Customer Service:

When calling or writing, please provide your Subscriber ID from your Blue Cross Blue Shield ID card. We offer translation services for non-English speaking members. Over 140 languages are available. You can obtain language assistance by calling the telephone inquiries phone number listed below.

Telephone Inquiries:	877-752-1233 (TTY users: start by dialing 711)

Note: You can get information about your coverage 24 hours a day through our interactive voice response system by calling the telephone inquiry phone number. See the "General Information" section of this handbook for more information about the IVR system.

Written Inquiries:	Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd. Mail Code 0400 Detroit, MI 48226
Visit the website:	**bcbsm.com** (login or register online to access your account)

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

Blue Cross Behavioral Health:	800-762-2382 **bcbsm.com**

Prescription Drug Plan:

Prescription drug inquiries:	877-752-1233
OptumRx® mail order prescription inquiries:	855-811-2223
Website:	**bcbsm.com** (login or register online to access your account)
Walgreens Pharmacy (specialty drugs)	866-515-1355

Hearing Plan:

Claims address:	Blue Cross Blue Shield of Michigan Member Claims MC 0010 600 E. Lafayette Blvd. Detroit, MI 48226
Visit the website:	**bcbsm.com** (login or register online to access your account)

Health Savings Account Inquiries:

877-284-9840	**bcbsm.com** (login or register online to access your account)

Network Provider Locator:

800-810-BLUE (2583)	**bcbsm.com** (you can access Network Providers online by clicking on "Find a Doctor")

Member Self Service:

This feature allows you to check on a claim you sent to us, get up to date information on your deductibles and out of pocket expenses, view or print EOBs or order a BCBS ID card.

Visit my health care benefits	**bcbsm.com** (login or register online to access your account)

Blue Cross Coordinated Care:

Call Monday through Friday from 8 a.m. to 5 p.m.:	800-775-BLUE (2583) TTY users call 711

Blue Cross® Well-Being℠:

Your benefits include Blue Cross Well-Being, our personalized program designed to help you learn as much as you can about your health. When you have the health information you need, you can make better decisions.

Blue Cross Well-Being provides you with educational resources to help you understand and manage a disease and interactive Web resources where you can learn about your health and how to improve it.

Call Monday through Friday from 8 a.m. to 6 p.m.:	800-775-BLUE (2583)
Or visit the Blue Cross Well-Being website:	**bcbsm.com** (login or register online to access your account)

This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Blue Cross Blue Shield of Michigan administers the benefit plan ***for your employer or plan sponsor and*** *provides administrative claims payment services only. Blue Cross Blue Shield of Michigan does not insure your coverage nor do we assume any financial risk or obligation with respect to your claims. Benefits and future changes in benefits are the responsibility of your employer. Information concerning members may be reviewed by* ***Blue Cross Blue Shield of Michigan, and may also be reviewed by your employer, on a limited basis, for specific purposes permitted by law****.*

This coverage is provided pursuant to a contract entered into in the state of Michigan and must be interpreted under the jurisdiction and according to the laws of the state of Michigan.

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GETTING STARTED

This handbook is filled with useful information on a variety of subjects, but we don't expect you to read it cover to cover! Instead, skim through it so that you will be familiar with the topics and where to find them if you need them. Then, read this section to learn the basics that everyone should know to get started. If you have any questions about your benefits or need help, call customer service at the number on the back of your ID Card.

How you share costs with us

As a Blue Cross member, you have help paying for your health care. However, some costs you share with us – here's how.

Beginning of your plan year

- You pay **copayments,** if applicable, for certain covered services, like doctor's office visits and urgent care.
- Depending on your plan, throughout the year BCBS pays for **certain preventive and wellness care at no cost** to you.
- You pay for **all other medical costs** until you meet your deductible, if your plan includes a deductible.

Once you have met your **deductible** (*if applicable*)

- You now pay **coinsurance** instead of the total cost, and continue to pay **copayments**, until the total you have paid for copayments, coinsurance and deductibles equals your out-of-pocket maximum.
- If there's more than one person on your plan, you may have to meet a family out-of-pocket maximum as well as an individual maximum.

Once you have reached the **out-of-pocket maximum**

- The plan pays for all other covered services. You don't owe a thing.

End of the plan year

- Your **deductible** and **out-of-pocket maximum** reset to zero for the next plan year.

Important Terms to Know

Copayment (or copay)
A fixed amount you pay for a covered health care service, usually when you get the service. ***When a copayment is charged, the service may also be subject to coinsurance.***

Deductible
The amount you owe for covered health care services before your health care plan begins to pay. ***The deductible may not apply to all services.***

Coinsurance
Your share of the costs of a covered health care service, usually a **percentage** (for example, 20 percent) of the allowed amount for the service. ***Your coinsurance also counts towards your out-of-pocket maximum.***

Out-of-Pocket Maximum
The most you'll pay in deductible, copayments and coinsurance during the year.

For details on your plan's coverage, refer to your "Benefits at a Glance."

Web or mobile, get the most from your plan

Health care can be confusing. To help you understand and manage your costs and care, we offer a wide range of tools, through your online member account at **bcbsm.com**. Once you register your account with a computer, nearly everything you can do on the website you can do on your smartphone or tablet.

Register for your online account

It only takes a few minutes to activate your account. Go to **bcbsm.com** and click *LOGIN* and follow the prompts. You'll need your **subscriber ID card** handy to complete the process.

You can also access your online account by using our app. To get our app, search "BCBSM" in the App Store® or Google Play™.

What can you find online or using the mobile app?

- **My Coverage** – Find detailed health plan information, who is on your health plan, what we pay for, what you pay for and more.
- **My Claims** – See a list of all claims.
- **ID Card** – Request additional member ID cards or view a virtual one.
- **Find Care** – This includes hospitals, urgent care, behavioral health services and 24-Hour Nurse Line.
- **Programs and Services** – Find health care services and well-being resources that are available through your plan.
- **Spending Accounts** – Review account balances and manage your health care spending account.
- **Forms and Documents** – Get claim and reimbursement forms and many other helpful resources to manage your health care benefits and care.
- **Discounts** – You'll have access to money-saving programs, such as Blue365®. This national program offers access to discounts and savings from selected companies on health-related products and services.

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Google Play and the Google Play logo are trademarks of Google LLC.

Search for doctors and hospitals

Your account helps you understand your choices about who to see and where to go for care in your plan's network.

Look up a doctor's name or specialty, places for health care services by name or type, or costs for a procedure.

If you want a pediatrician near your child's day care center or a primary doctor closer to work, reset the location to get a broader list of in-network doctors.

Selecting the doctor's name shows you:

- Office location
- Office hours
- Health care plans accepted
- If virtual care is available
- Specialties
- If new patients are accepted
- Languages spoken
- Group and hospital affiliations
- Board certifications
- Review the profiles of your top choices so you can determine the right doctor for you.

Compare costs for services and procedures

Your account gives prices for many health care services, based on actual costs. See the average cost for a service and how it can differ by doctor, location or type of facility.

Costs can vary. Sometimes you can save money by driving 15 minutes more or having your procedure at an outpatient facility rather than in a hospital.

Plan ahead for surgeries

Get an idea of the costs you can expect for surgery. Let's say your doctor recommends knee replacement surgery. Your account sums up the estimated cost for each service involved with your procedure — from your first doctor visit to post-surgery physical therapy. With this information, you can see how long it could take and how much it may cost to have your knee replaced.

You'll also see where you can save money. Using our example, you may find that six weeks of physical therapy costs less at a nearby outpatient clinic than the hospital. Knowing costs ahead of time helps you plan for care and manage your benefits.

You have the power to choose.

Use your account to explore options and costs and talk with your doctor to make informed decisions about your care.

Your online member account is your health care resource for coverage and care.

Choosing the right place for care

We've got you covered with care that's always there. When it's not an emergency, you have smart choices for care that will help you get the care you need, when you need it.

Primary care provider	24-Hour Nurse Line	Virtual Care	Walk-in clinics	
			Retail health clinics	Urgent care centers
AVERAGE WAIT TIME FOR CARE 30 minutes	**AVERAGE WAIT TIME FOR CARE** 1 minute	**AVERAGE WAIT TIME FOR CARE** 10 minutes	**AVERAGE WAIT TIME FOR CARE** 30 to 60 minutes	
APPOINTMENT REQUIRED? Yes	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	
AVAILABILITY In person, by phone, virtually	**AVAILABILITY** By phone	**AVAILABILITY** Virtually through the Teladoc Health® app	**AVAILABILITY** In person	
TREATMENT Start here when you want to talk with a doctor you know and trust. • High-quality, comprehensive care • Knows you and your medical history and coordinates all your care • Many primary care offices offer virtual care, same-day appointments, extended hours and other services • You may have Virtual Primary Care through Teladoc Health (for Blue Cross; PPO members*)	**TREATMENT** When you have questions about an illness or injury, anytime day or night • No cost • Available by phone anytime, anywhere in the U.S. • Care provided by a registered nurse	**TREATMENT** When you want to talk to a doctor or therapist virtually from your mobile device or telephone • Video chat 24/7 with a provider or therapist anywhere is the U.S. • Send a visit summary to your primary doctor • Care provided by U.S. board certified doctors and therapists • Prescriptions, if needed, can be sent to a pharmacy you prefer	**TREATMENT** For a quick, in-person evaluation to get minor health care and a prescription at one location • Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board-certified doctor	**TREATMENT** When your symptoms are a little more complicated and you need convenient, in-person care • Evening and weekend hours • Convenient locations • May offer labs and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms

*Remember to coordinate all your care with your primary care provider. Follow-up with him or her after receiving care elsewhere.

Learn about care that's always there at bcbsm.com/findcare.

Teladoc Health is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

We want to limit the number of forms you need to fill out. Most doctors file claims electronically after your visits. Many activities, such as updating your plan information, can be done online or with a call to our Customer Service department.

Your Explanation of Benefits statement

Your Explanation of Benefits, or EOB, statement shows you the costs associated with the medical care you've received. When a claim is filed under your benefit plan, you'll receive an EOB showing what was billed, any Blue Cross discounts, what we paid and what you pay.

Your EOB can be sent via mail or can be viewed online by logging in to your account at **bcbsm.com** or on our mobile app. You can view a history of your doctor visits, services received and how much we paid and more. Your statements are available online for five years.

EOB Statement Details

1. This identifies who this EOB statement is for.
2. Summarizes claims by doctor, hospital, or other health care provider as follows:
   - (A) This represents the amount submitted to Blue Cross on the claim.
   - (B) What you saved by being a Blue Cross member.
   - (C) What we paid and amounts your other insurance(s) paid.
   - (D) What you pay. You may have already paid or may still owe this amount. You should never be asked to pay more than this amount.
3. Shows the balances to date for deductibles and out-of-pocket maximums for your current benefit period.
4. Important information about your coverage, tips to lower health care costs and ways to improve overall health.

EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Statement Date : 04/25/23

0012345-1234-1234
PAUL MEMBER
1234 MAIN STREET
HEALTHWAY MI 99999-9999

Customer Service
Web: View your benefits and manage your plan online at bcbsm.com
Call: 1-800-999-9999 TTY 711
Mail: BLUE CROSS BLUE SHIELD OF MICHIGAN
CUSTOMER SERVICE
ANYTOWN, MI 99999-9999

(1)

Patient Name:	PAUL MEMBER
Patient Born In:	JUNE 1985
Subscriber Name:	PAUL MEMBER
Subscriber ID:	*****2345
Group Name:	COMPANY NAME
Group Number:	0012345-1234
Coverage:	MEDICAL

For suspected fraud, call 1-800-482-3787 TTY 711

(2) **Claim Summary** (for Claim Detail, see below)

Hospital, Doctor or Other Health Care Provider	(A) Total Charges	(B) minus Discount *	(C) minus Plan Paid	minus Other Insurance Paid	(D) equals Amount You Pay
DOCTOR A	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95
	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95

* Blue Cross discounts are negotiated with hospitals, doctors and other health care providers which saves you money.

(3) **Summary of Deductibles and Out-of-pocket Maximums**
(For more detail on your current blanaces, log in at bcbsm.com or our mobile app. Click on My Coverage, then Medical.)

Totals for Health Plan
BENEFIT PERIOD: Jan. 01, 2023 through Dec. 31, 2023

In-network deductible applied to date:	$ 3,000.00
In-network out-of-pocket maximum applied to date:	$ 3,027.95
In-network coinsurance applied to date:	$ 27.95

Helpful Information

All Explanation of Benefit statements now show only the last four digits of your enrollee ID. We hide the first five digits with *****. Your privacy is important to us, and this is one way we're working hard to protect it. We suggest you have your Blue Cross ID card ready if you call us.

(4) Log in at bcbsm.com to see a personal snapshot of your coverage. You can see your recent claims, deductible and out-of-pocket balances, and other information. To avoid clutter, sign up for paperless EOB statements. We'll send you an email when a new statement is ready to view. It's easy - go to bcbsm.com to log in.

5. This section shows detailed information about each claim we processed.

   It provides additional detail about the types of cost sharing applied to the claim. The sum of all claims in this section for the same provider should match the numbers in the Claim Summary section.
   - (E) Information your provider puts on the claim to identify the medical service you received.
   - (F) The unique number Blue Cross assigns to a claim. You can reference this number if you need to call us about this claim.

EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Statement Date : 04/25/23

(5) **Claim Detail** Subcriber ID: **** 1234 Patient: PAUL MEMBER

Provider Name:	DOCTOR A	Total charge	$ 66.00
Provider Status:	PARTICIPATING		
Service Dates:	03/24/23	Amount approved by Blue Cross for this service	24.74
Service Type:	OTHER MEDICAL SERVICES	In-network coinsurance you pay	- 4.95
(E) Procedure:	INJ IRON DEXTRAN	Your plan paid this provider on 04/22/16	19.79
Procedure Code:	J1750	Discount	+ 41.26
Claim Received:	04/03/23	Total covered	$ 61.05
(F) Claim Number:	99999999999999		
		Amount You Pay	$ 4.95

Page 2 of your statement shows your appeal rights and what you can do if you disagree with any of the benefit decisions made for a claim. You can also find definitions for terms used on the statement.

Important information you should know about your Explanation of Benefit Payments statement

Your appeal rights

If this statement shows a balance for a reduced or denied service, and you disagree with the amount, Customer Service might be able to help. The phone number is on the back of your ID card and the top right corner of page 1 of this form.

If you ask, we must give you access to and copies of the documents related to your claim. We won't charge you for the copies. Within the limits of other privacy laws that we must obey, upon request, we'll share treatment and diagnosis codes with you. We'll also include the meaning of the codes reported by health care providers.

To ask for an internal appeal when you disagree with our decision, you must

Help with terms you might see on this statement

Amount approved – Our maximum payment allowed for a service. For some patients, this amount is decided by Medicare or other insurers.

Amount you pay – This amount is your share of the cost for health services and is based on the benefits in your Blue Cross health care plan. Your health care provider should not ask you to pay more than this amount.

Benefit period – The time period (usually one year) during which your deductibles and coinsurance accumulate.

Claim number and received date – The unique number we assign to a claim and when we received it.

Thank you for taking the time to become familiar with your Explanation of Benefits statement. If you have questions, call the number on the front of your statement.

Understanding Your ID card

Your ID card tells doctors and other health care providers that you are eligible for services covered under your health care plan with Blue Cross Blue Shield of Michigan. You should always carry it with you, and make sure you have the latest card. Using outdated cards may delay payment of claims.

➢ Note: All cards will show the subscriber's name, even those issued to family members. If you are not the subscriber, your card will not have your name on it.

Below is a *sample* ID card that highlights information you may need.

❶ **Subscriber name:** The subscriber's name.

❷ **Subscriber ID:** The subscriber's assigned contract number, which allows health care providers to identify you and your benefits.

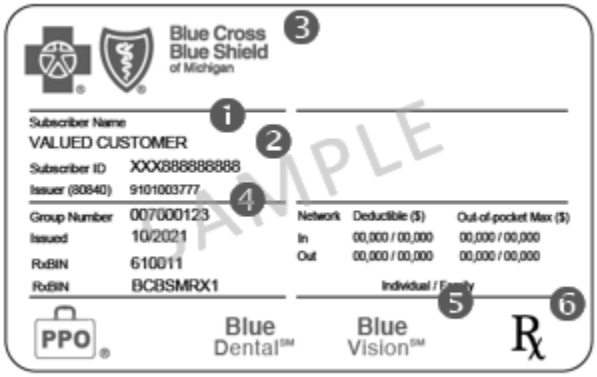
❸ **Issuer:** Identifies you as a Michigan Blue Cross member to out-of-state providers.

❹ **Group number:** Identifies your employer group.

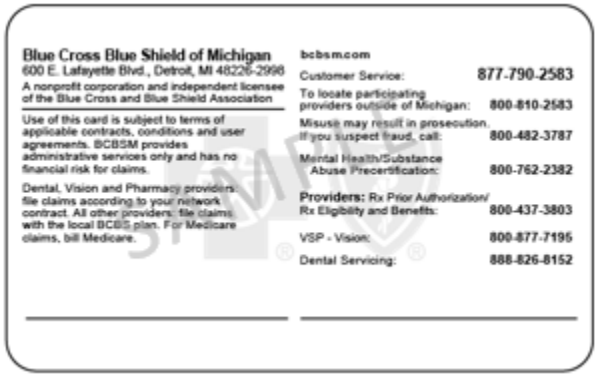
❺ & ❻ These icons are present if your coverage includes dental or prescription drugs.

Customer service phone numbers for you and your providers are located on the back of your ID card.

Card front



Card back



Lost or stolen cards

You can replace lost or stolen cards by calling a customer service representative at the toll-free phone number listed on the inside front cover of this handbook. You can also visit **bcbsm.com** or use the mobile app to request additional cards or view a virtual one.

If your card is lost or stolen, you can still receive services, but you should report the loss of your card immediately to your employer and Blue Cross. You can also access your member ID card through the mobile app or your online member account.

Understanding your Health Savings Account

A health savings account, or HSA, is like a 401(k) for health care. It is a tax-advantaged personal savings or investment account that individuals can use to save and pay for qualified health care expenses, now or in the future. Paired with a qualified high-deductible health plan, an HSA is a powerful financial tool that empowers consumers to be more actively involved in their health care decisions.

However, unlike other financial savings vehicles (Roth IRA, Traditional IRA, 401K, etc.), an HSA has the unique potential to offer triple tax savings through:

- Pre-tax or tax-deductible contributions to the HSA
- Tax-free interest or investment earnings
- Tax-free distributions, when used for qualified medical expenses

Contributions can be made by the employer, the employee or individual, or both. Tax-free withdrawals can be made to pay for qualified health care expenses incurred by the account holder, spouse, children and other dependents.

HSAs are also portable, which means that individuals keep their HSAs, if changing jobs or becoming unemployed. Also, since the account is owned by the individual, there is no “use-it-or-lose-it” provision, like with a flexible spending account. Instead, unused contributions roll over each year, with interest or investment earnings compounding on a tax-free basis, like an IRA or 401(k). HSAs offer the potential for long term, tax-free savings that can be used for future health care expenses, such as Medicare premiums and certain long-term care expenses and insurance.

Any adult who is not already enrolled in Medicare and is covered by a high-deductible health plan (and has no other first dollar coverage except for preventive care) may establish an HSA. There are no income limitations.

Here’s how it works

Universal HSA principles for consumers

- You must be enrolled in an HSA-qualified high-deductible health plan to open or contribute to a health savings account in your own name.
- Switching to a high-deductible health plan from a traditional low deductible health plan will substantially lower your health plan premium. The money you save in premiums can be deposited into your HSA.
- The money in your HSA is entirely your own. Even if your employer makes contributions to your HSA, you control how the funds are spent for qualified medical expenses. Since it is your money, it also stays with you when you change jobs.
- You are in charge of your HSA funds, making you and your doctor the decision makers, not a third party. Spending your own money also means you can shop around for the best value.

- There is no time limit as to when you can reimburse yourself for your health care expenses; you just need to keep legible receipts and records in case you are audited.
- You decide whether and how much to spend from the account for your medical expenses, whether to spend out-of-pocket or to save the HSA money for the future. Just like a 401(k), earnings that compound tax-free for several years have the potential to grow exponentially into a supplemental retirement nest egg. After age 65 (or if you're disabled), funds can be withdrawn for nonqualified expenses without being subject to the 20 percent penalty, but ordinary income taxes still apply.
- Anyone can contribute to another person's HSA. The tax benefit from such a contribution is gained by the person receiving the contribution, not the person giving the contribution.
- You decide which company will hold your HSA money (your trustee or custodian) and what type of investments you make with your account. Any investment allowed for IRAs is allowed for HSAs.
- IRS Publication 502 provides a list of most allowable HSA expenditures and publication 969 further explains the HSA product.

Value of Blue

Blue Cross® Well-Being℠

Blue Cross Well-Being offers online resources that can can help you get and stay healthy. We work with Personify Health™ to offer you an enhanced well-being experience that includes:

- **Fitness tracking** — You can sync data from your fitness app or tracker to Blue Cross Well-Being. Seamlessly connect with more than 100 devices and apps, including Apple Health, Fitbit and MyFitnessPal.
- **Health assessment** — Learn your strengths as well as areas for improvement and get personalized recommendations.
- **Journeys®** — Over 60 lifestyle and health-related self-guided courses are available.
- **Tobacco Coaching** — If you're ready to stop smoking, vaping or using nicotine, this program pairs you with an experienced coach who offers support personalized to your specific interests and needs. The same coach stays with you throughout your journey to quit. You can connect with your coach by phone or through in-app messaging.
- **Daily Cards** — Every day we'll send you two new tips to help you live well. Plus, we'll make sure they're about the areas that interest you the most.
- **Healthy habits** — Get bite-size ways to build a healthy routine and improve your well-being. Your healthy habits will be customized based on your health assessment results and the interests you set in your profile.
- **My Care Checklist** — This handy health care tracker assists you in managing your health by keeping track of well visits, screenings and vaccinations — all in one place.
- **Nutrition Guide** — Choose what you'd like to work on, like cutting out sweets or portion control. Then get tips and recipes to help you achieve your goals.
- **Sleep Guide** — What's your sleep like? Decide what you need to work on, like getting to bed earlier or quieting down. Then get information to help you rest.

You can access these resources through your member account at **bcbsm.com** or our mobile app. Just log in and select *Wellness* under the *Programs & Services* tab. Then scroll down to *Blue Cross Well-Being* and select *Go to Blue Cross Well-Being*. First-time visitors will need to enroll.

Other resources

Blue Cross Virtual Well-Being℠

Blue Cross Virtual Well-Being offers live, 30-minute, interactive webinars on Thursdays at noon Eastern time focused on engaging and inspiring people to enhance their overall well-being. Every webinar includes a science-based discussion of well-being topics, such as menopause, functional fitness and learning to respond rather than react.

In addition to webinars, guided meditations are presented live each Wednesday at noon Eastern time. All webinars and meditations are also available on-demand. Register for webinars or meditations and learn more at **bluecrossvirtualwellbeing.com**.

Blue365®

Our member discount program gives you exclusive deals on health-related products and services, such as fitness gear, gym memberships, travel and personal care products. Log in to your member account to see available discounts.

Engagement Center

The answers you need are a phone call away. Our knowledgeable Engagement Center assistants can answer your questions about the well-being programs available to you.

Engagement Center assistants can also:

- Help you find network doctors and hospitals
- Answer questions about well-being program incentive requirements (for eligible participants)
- Give you information about program discounts
- Assist with online well-being resources
- Direct you to a registered nurse for health information and symptom management, when necessary (for eligible participants)

Call 1-800-775-BLUE (2583)

Monday through Friday

8 a.m. to 5 p.m. Eastern time

All calls are toll-free and strictly confidential.

24-Hour Nurse Line

Our 24-Hour Nurse Line gives you access to registered nurses who are ready to answer your health care questions 24 hours a day, seven days a week.

You can talk to a nurse about:

- Symptom management
- Health information
- Audio health library

How to get started

Call 1-844-811-8460.

AHealthierMichigan.org

This blog site shares information on everything from good mental health to smoothie recipes and workout hacks. Visit ahealthiermichigan.org to explore.

Preventing fraud

Health insurance fraud raises health care costs for everyone. Blue Cross Blue Shield of Michigan works diligently to prevent fraudulent use of your ID card. Only you and your eligible dependents may use the cards issued for your health care plan. Lending your card to anyone not eligible to use it is illegal. Your health care provider may ask for identification other than your ID card, such as your driver's license. Checking identification helps prevent unauthorized use of your card.

You can help by reporting fraud

Remember, information you give us about suspected fraud is confidential. We'll never tell anyone that it came from you.

Anti-Fraud Hotline: 800-482-3787

Medicare Anti-Fraud Hotline: 888-650-8136 (TTY users call 711)

You can also report fraud through our website at: **http://www.bcbsm.com/health-care-fraud/index.html**.

Selecting a health care provider

This section explains how to find a network provider, locally or when travelling. Using a network provider saves you the most on your out-of-pocket costs. Covered services must be provided by BCBSM-approved providers who are legally qualified or licensed to provide them.

Your benefits are provided through the preferred provider organization health care plan. This plan provides you with the highest level of benefit payment and limits your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the PPO health care provider network.

The level of a health care provider's participation affects your out-of-pocket costs. The levels are:

- Network providers
- Out-of-network, but participating, providers
- Nonparticipating providers

Network providers

To receive the highest benefit payment level, you should use health care providers who are in the PPO network. Network providers have signed agreements with Blue Cross, which means they agree to accept our approved payment, for a covered benefit, as payment in full. You will only pay for the in-network deductibles, coinsurances and copayments required by your coverage.

Ask your physician if he or she is in the PPO network in your plan area. If you need help locating a network provider, please call customer service to locate a network provider or visit the website listed on the inside front cover of this handbook.

When you go to a network provider, you do not have to send a claim to us. Network providers submit claims to us for you, and they are paid directly by us.

Out-of-network but participating providers

Although many providers are part of our PPO network, you have the freedom to visit an out-of-network provider and still receive coverage for covered services. Providers who are not part of the PPO network are called out-of-network providers.

When using an out-of-network provider, try to use a Blue Cross participating provider. Out-of-network but participating providers have signed agreements with us to accept our approved amount as payment in full for covered services. However, because these providers are not part of the PPO network, you must pay any required copayments and a higher deductible and coinsurance for your care.

When you go to out-of-network but participating providers, you usually don't have to submit claims. These providers, like network providers, submit claims to us for you and the providers are paid directly by us.

Nonparticipating providers

Nonparticipating providers have not signed agreements with Blue Cross. This means they may or may not choose to accept our approved amount as payment in full for your health care services.

If your health care providers do not participate with Blue Cross, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per-claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, coinsurances and copayments required by your plan along with charges for noncovered services.

You are usually required to pay nonparticipating providers directly and then you will submit the claim to us for reimbursement. Remember, the amount we reimburse you may be less than the amount your provider charged. You are responsible for the amount the provider charged above our approved amount.

Surprise Billing

Federal and Michigan state law require us to pay nonparticipating providers certain rates for covered services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, we will pay the provider directly, and you will only pay the cost share applicable to that service as defined in federal or Michigan law. The cost share you pay for these services will apply to your in-network deductible and in-network out-of-pocket maximum. The following situations are covered by the surprise billing laws:

- Covered emergency services at a participating or a nonparticipating facility
  - Emergency services are covered regardless of whether the facility is participating or nonparticipating.
  - If you receive emergency services rendered by a nonparticipating facility or provider, administrative requirements will be the same, regardless of the facility's participating status.
- Covered non-emergency services provided by nonparticipating providers in the following participating facilities: hospitals, critical access hospitals, hospital outpatient departments, and surgery centers.
  - You can waive surprise billing protections if you sign a notice and consent form.
  - Certain "ancillary" providers are not allowed to ask you to waive your surprise billing protections. These include anesthesiologists, pathologists, emergency medicine providers, radiologists, neonatologists, hospitalists, and surgical assistants.
- Covered air ambulance services

Change of physician network status

Your physician is your partner in managing your health care. However, physicians retire, move, or end their affiliation with the PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network.

If you wish, you may continue your medical care with a physician who is no longer with the PPO network; however, you may be responsible for the difference between our approved amount and

the provider's charges, in addition to any deductibles, coinsurances and copayments required by your plan.

You can find physicians and hospitals in your area by calling the network provider locator or by visiting the website listed on the inside front cover of this handbook. You do not have to notify us when you select or change providers. To make your appointment, just call the physician's office directly.

Emergency services by out-of-network providers

When an emergency occurs, you need to seek care from the nearest provider who may not always be a network provider. If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, your services will be paid at the in-network benefit level. **The treatment must be for a true emergency as determined by Blue Cross Blue Shield.** See the "Your health care benefits" section of this handbook to find out what qualifies as a medical emergency.

Referral to out-of-network providers

There may be times when your network physician will refer you to another physician, such as a specialist. Usually, your physician will refer you to a physician that is in the PPO network. If you are referred to an out-of-network physician, please contact your Blue Cross customer service representative to verify the referral process before receiving services. Covered medical services received from a referred physician may be subject to extra out-of-pocket costs.

Coverage when you travel

When you travel across the country or around the world, your health care benefits go with you. The BlueCard® program gives you access to doctors, hospitals and other providers everywhere you travel.

Travel across the United States

Our extensive provider network makes it easy to find participating doctors, hospitals and other providers when you travel away from home. Out-of-state participating providers will bill their local Blue plan for any covered services you receive. This means faster payment to the provider and less out-of-pocket costs for you. Here's how it works:

- **Participating providers** — Present your Blue Cross ID card to out-of-state participating providers. They will bill their local Blue plan for payment. Your provider also will accept the approved amount or negotiated rate (see "Glossary of health care terms") as payment in full. You are responsible for any member out-of-pocket costs (deductibles, coinsurances and copayments) as identified in this handbook. Remember, your out-of-pocket costs are usually calculated on the lower of the provider's actual charge or the Blue Cross approved amount or negotiated rate.

  Note: If a participating provider bills you for charges other than what is required by your plan, remind the provider that he or she should accept the Blue Cross payment as payment in full.
- **Nonparticipating provider** — If your out-of-state provider does not participate with the local Blue plan, ask if the provider can send the bill directly to us. If not, you will need to get an

itemized receipt and send it to us for reimbursement. See the “Filing claims” section of this handbook for instructions on how to submit a claim.

Travel outside of the United States

When you travel outside of the United States, you still have access to your benefits as long as services are provided by a licensed physician or an accredited hospital.

Most hospitals and doctors in foreign countries will ask you to pay the bill up front. Try to get itemized receipts, preferably written in English.

When you submit your claim, please indicate if the charges are in U.S. or foreign currency. Be sure to also indicate whether payment should go to you or to the provider. Blue Cross will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, less any deductibles, coinsurances and copayments that may apply.

BlueCard program

Out-of-Area Services Overview

Blue Cross Blue Shield of Michigan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area Blue Cross serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Blue Cross’ service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. Blue Cross explains below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Blue Cross to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Blue Cross will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside Blue Cross’ service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Blue Cross has used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Blue Cross may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price on our website **bcbsm.com** under Section A, BlueCard Program) made available to Blue Cross by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the 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 is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than any related patient cost sharing under this contract.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Blue Cross on your behalf, Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Nonparticipating Providers Outside Blue Cross' Service Area

Member Liability Calculation

When Covered Services are provided outside of Blue Cross' service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Blue Cross will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

In certain situations, Blue Cross may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount Blue Cross will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment Blue Cross will make for the Covered Services as set forth in this paragraph.

BlueCard Global Core® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Global Core® Program when accessing Covered Services. The BlueCard Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Global Core Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the BlueCard Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Blue Cross to obtain precertification for non-emergency inpatient services.**

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Global Core Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Global Core claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross, the BlueCard Global Core Service Center or online at **bcbsglobalcore.com**. If you need assistance with your claim submission, you should call the BlueCard Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

ELIGIBILITY AND ENROLLMENT GUIDELINES

This section explains who is eligible to be covered under your plan. It also explains how to add or remove dependents.

Enrolling in your plan

When you are eligible to enroll for health care coverage, your employer will provide you with an application and assist you with the enrollment process. You may also enroll your spouse and eligible dependents.

To make sure that these eligibility records are kept up to date, you must promptly report any changes (birth of a newborn, change of address, marriage, etc.) to your employer.

Eligible dependents

Eligible dependents are defined as those related to you by birth, marriage, legal adoption or legal guardianship. Dependent children's eligibility is through the end of the month in which the dependent turns 26.

Eligible dependents include:

- **Your spouse** (an individual you are legally married to and meets your employer's eligibility requirements)
- **Biological children**
- **Adopted children** may be enrolled as of the date of final adoption or the date of a petition for adoption if the child resides with the subscriber and the subscriber notifies us. In either case, we must be notified within 30 days of the date of final adoption or the date of the petition for adoption. A copy of the petition for adoption must be submitted.
- **Dependent stepchildren** are eligible when a subscriber marries someone who has dependent children. The subscriber must add the spouse and stepchildren within 30 days of the marriage. The coverage effective date for the spouse and stepchildren will be the date of marriage. If the spouse and dependent stepchildren are not added within 30 days of marriage, they can be added at your group's annual open enrollment period.
- **Children under legal guardianship** are eligible to enroll under a subscriber's contract on the date legal guardianship is granted to the subscriber or prior to that date if the subscriber has filed a petition for legal guardianship and the child has established residency with the subscriber. When notification is made within 30 days of the date of either of these events, coverage for the children will become effective as of the date of the event. **One** of the following documents is required:
  - A sworn statement that includes the date of petition for legal guardianship and the date the child established residency
  - A statement from the court verifying legal guardianship has been granted
- **Children eligible because a court order** puts responsibility for the dependents' health care on the subscriber or the spouse are eligible for coverage immediately.

Sponsored dependents

A dependent who is older than 19 and not eligible for continuation coverage may be eligible for coverage as a "sponsored dependent." To be eligible, the dependent must meet all the following requirements:

- Be related to you by blood, marriage, legal adoption or legal guardianship
- Reside with you as a member of your household
- Be dependent on you for more than half of their support
- Cannot be eligible for Medicare

You are responsible for paying the cost of coverage for each sponsored dependent.

Disabled dependents

Disabled dependents are eligible for coverage under your contract at any age if they are totally and permanently disabled by age 26, and **you notify your employer in writing of the condition no later than 30 days after the end of the month the child turns 26**. The disability must be due to developmental disability or physical disability that prevents a dependent from being self-supporting.

Disabled dependents must be unmarried and dependent on you for support and maintenance to be covered. You will be required to provide verification of a dependent's total and permanent disability.

Making membership changes — your responsibility

It is important that your membership records be kept up-to-date so we can process your claims quickly and correctly. Please report any changes to your employer promptly. Any changes involving adding or removing a dependent due to marriage, birth, divorce, dependent no longer eligible for coverage, etc. or changing an address, must be made within 30 days of the change.

Health care coverage eligibility chart

The table below shows when you are qualified for coverage.

Eligible employee or dependent	Qualification for coverage
Dependent children	Coverage continues until the end of the month in which the dependent turns 26
Disabled dependents	Must be totally and permanently disabled and **you must notify your employer no later than 30 days after the end of the month the child turns 26.**

When coverage ends

The chart below gives the reason and the end date of coverage when removing dependents.

Dependent type	Reason for losing coverage	Effective end date of coverage
Spouse	Divorce or legal separation	Date of divorce or legal separation
Dependent children	Passed age of eligibility	Coverage continues until the end of the month in which the dependent turns 26

Special enrollment periods

If you decline to enroll

If you decline enrollment for yourself or your dependents (including your spouse) because you have coverage under another health insurance plan, you may in the future enroll yourself and your dependents in this plan, if:

- The other coverage is terminated as a result of loss of eligibility or termination of employer contributions for the other coverage, provided that you request enrollment within 30 days after your other coverage or the employer contribution toward that coverage ends. "**Loss of eligibility**" includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim.
- You have a new dependent as a result of marriage, birth, adoption, placement for adoption or legal guardianship, provided that you request enrollment within 30 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

If you declined enrollment because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan under a special enrollment period. Otherwise, you must wait until the next annual open enrollment period.

Continuing health care coverage on your own — COBRA

When you are no longer eligible for health care coverage through your employer, coverage for you and your dependents ends. However, you may continue temporary coverage through your employer. This is called **COBRA continuation coverage**. The Consolidated Omnibus Budget Reconciliation Act, or COBRA, is a federal law that requires employers of 20 or more people to offer a temporary extension of coverage to those who lose group coverage. This extension applies to the employee, spouse and dependent children, including children born or adopted after you become eligible for COBRA, who are enrolled within 60 days of the qualifying event. The person who lost the group coverage is called a "qualified beneficiary."

Your employer will notify you and your dependents when you are eligible for this temporary extension of your health care coverage. In the case of your death, your employer must notify your dependents about their eligibility. In case of divorce, you or your former spouse must notify the employer within 60 days in order to be eligible for this coverage. COBRA coverage must be elected

within 60 days after you lose coverage or 60 days after your employer sends you notice. In every case, you (or your dependents) must notify your employer within 60 days of your decision to continue coverage through your employer. The length of time this continuation coverage is available to you and your dependents depends on the reason you become eligible for this coverage. You or your dependents will be required to pay the entire applicable cost of coverage, plus an administrative fee.

Employee continuation coverage

If you lose your coverage because of layoff, reduction in your hours of employment or termination of your employment (for other than gross misconduct), coverage is available to you and your dependents for up to 18 months.

Continuation coverage is extended to 29 months if:

- You or any qualified beneficiaries are certified as disabled by the Social Security Administration at the time coverage is terminated.
- You or any qualified beneficiaries are determined to be disabled by the Social Security Administration any time during the first 60 days of COBRA coverage.

Dependent continuation coverage

Your dependents have the right to continue their coverage for up to 36 months when they are no longer eligible under your plan because:

- Your dependents' coverage under the plan ends due to your death.
- You become eligible for Medicare and your spouse or dependents lose group coverage as a result.
- Divorce or legal separation causes a spouse to lose coverage.
- Children no longer meet dependent eligibility requirements under your plan.

Level of continuation coverage

If you or your dependents choose COBRA continuation coverage through your employer, you will be offered the same level of benefits as active employees.

You may continue the COBRA coverage you select until the earliest of the following situations:

- The end of your continuation period
- The date your employer no longer provides coverage to any of its employees
- The date you do not make payment for COBRA coverage
- The date you or your dependents become covered under another group health care plan (unless that plan includes exclusions or limitations about pre-existing conditions that apply to you)
- The date you or your dependents become entitled to Medicare

Children's Health Insurance Program Reauthorization Act

The Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA, requires all health plans to allow a special enrollment period should you or your dependents lose eligibility under Medicaid or Children's Health Insurance Program coverage through states participating in a premium share subsidy to eligible participants.

You and your eligible dependents have 60 days to enroll in your group's health plan under the following two circumstances:

- If you or your eligible dependents' Medicaid or CHIP coverage is terminated due to loss of eligibility
- If you or your dependents become eligible for a premium assistance program in the state in which you reside

If you are enrolled in such a program, your health plan will not accept direct payment from the state. Your group health plan is primary to any coverage under CHIP.

YOUR HEALTH CARE BENEFITS

This section explains your benefits for medical services in a hospital or doctor's office. You should review what is covered before you receive treatment to make sure services are covered. Benefits covered include:

- **Emergency care** – what is covered in case of an emergency or accident
- **Office visits** – how visits to your doctor are covered
- **Preventive care** – describes your benefits for regular checkups and screenings
- **Maternity care** – what is covered when you or a dependent is expecting
- **Inpatient care** – what is covered while in the hospital
- **Outpatient care** – what services are covered outside of a hospital such as your doctor's office or clinic
- **Additional benefits** — coverage for benefits such as chiropractor, hemodialysis, durable medical equipment, etc.
- **Physical, speech and occupational therapy** – what we cover for therapy
- **Autism care** – what our autism benefits cover
- **Transplants** – how your coverage works when you need a transplant
- **Behavioral Health (Mental Health and Substance Use Disorder Services)** – when you need treatment for mental health or substance use disorder concerns

Your deductible, coinsurance, copayment and benefit maximums apply to all benefits unless otherwise indicated.

Emergency care

You are covered for treatment of accidental injuries or conditions that we determine are medical emergencies. If you're not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it's best to call your doctor or your doctor's after-hours phone number. Emergency care includes the following benefits:

Emergency room

You are covered for treatment of accidental injuries or conditions that we determine are medical emergencies.

- An **accidental injury** is physical damage caused by an action, object or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises, allergic reactions, frostbite, sunburn and sunstroke; swallowing poisons, medication overdosing, and inhaling smoke, carbon monoxide or fumes.
- A **medical emergency** is something that happens suddenly and can result in serious bodily harm or threaten life unless treated right away such as a heart attack or stroke. This is not a condition caused by an accidental injury.

Emergency care also covers physician services for the exam and treatment of accidental injuries and medical emergencies.

Urgent care centers

You can also visit a network urgent care center for nonemergency conditions such as earaches, colds, flu, minor burns, fever, sprains, sore throats and headaches. Visit **bcbsm.com** for a list of urgent care centers near you.

Ambulance services

If a ground or air ambulance is needed due to an injury, medical emergency or admission, the service is covered when provided by a licensed ambulance company. Coverage includes equipment used, limited mileage and waiting time. A member may be moved to or from a hospital, or between hospitals or other approved medical facilities. Travel between hospitals must be medically necessary and ordered by the patient's physician. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.

Note: Non-emergency air ambulance services require prior authorization.

Office visits, Telemedicine and Virtual visits

You are covered for visits to a doctor's office, outpatient clinic or outpatient department of a hospital for the examination, diagnosis and treatment of general medical conditions. Services include medical care, consultations, medications and injections.

If your provider offers Telemedicine visits, these are covered and are subject to your office visit cost share requirements.

Your benefits also include coverage for virtual visits provided by doctors with secure technology. To use virtual visits:

- Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app
- Call 800-835-2362

Please call customer service for additional information.

Vitual visits are available in all states.

Preventive care

You have coverage for preventive care as required by the Affordable Care Act. As part of this law, you do not have a copayment, coinsurance or deductible when you receive preventive care, which include:

- **Routine health maintenance exams**
- **Routine gynecological exams**
- **Well-child care** — benefits include visits to a physician to monitor the development of a child.

- **Laboratory and screening services** — coverage for routine laboratory, diagnostic tests and X-rays related to a routine exam including but not limited to:
  - Chemical profile
  - Complete blood count (CBC)
  - Fecal occult blood screening
  - Urinalysis
  - Chest X-ray
  - EKG
- **Endoscopic procedures** — coverage for the following when performed as routine screening:
  - Colonoscopy
  - Sigmoidoscopy
  - Flexible sigmoidoscopy
  - Procto-sigmoidoscopy
- **Routine mammograms** — coverage for a routine breast X-ray exam using digital, including 3-dimensional imaging, and/or film imaging for members. More frequent mammograms are covered under diagnostic services if requested by your physician because of a suspected or actual presence of disease or when required as a post-operative procedure.
- **Pap smears** — coverage for laboratory services for a routine pap smear. More frequent pap smears are covered under diagnostic services for the following conditions:
  - Previous surgery for vaginal, cervical or uterine malignancy
  - Presence of a suspected lesion in the vaginal, cervical or uterine areas
- **Prostate specific antigen screening** — coverage for a PSA screening laboratory test.
- **Immunizations and vaccines —** coverage includes the following:
  - Childhood and adult immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by Blue Cross that comply with the provisions of the Affordable Care Act.
  - Human papilloma virus, or HPV, vaccine for dependents age 9 to 26.
  - Travel immunizations (such as rabies, typhoid, yellow fever, and Japanese encephalitis)
- **Counseling** to help you quit smoking, lose weight, eat healthfully, treat depression and reduce alcohol use
- **Additional women's benefits**
  - Screening for gestational diabetes
  - Counseling for sexually transmitted diseases
  - Counseling and screening for Human immune-deficiency virus, or HIV
  - Screening and counseling for interpersonal and domestic violence
  - Contraceptive counseling and methods (including anesthesia for contraceptive surgeries)
  - Breastfeeding supplies

Maternity care

Your coverage for obstetrical care includes delivery, delivery room costs, ordinary nursery care, and pre- and post-natal care visits. The initial exam of the newborn is covered when performed by a physician other than the delivering provider. The termination of pregnancy is covered regardless of medical necessity. Maternity services are covered for dependents.

➢ **Note:** Maternity care benefits are also payable when provided by a certified nurse midwife. Delivery must be in a hospital or Blue Cross-approved birthing center.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prescribed contraceptive devices

Your coverage includes physician-prescribed contraceptive devices such as diaphragms and IUD or contraceptive implants designed to prevent pregnancy.

Inpatient care

For an approved admission, your plan covers the following services. All benefits are subject to any deductibles, coinsurances, copayments or benefit maximums.

Precertification of hospital admissions

Precertification is required for all inpatient admissions to determine if the admission or service is appropriate, unless the admission is due to a medical emergency. Your doctor requests and coordinates the approval with the hospital and Blue Cross. This eliminates unnecessary inpatient care and determines an appropriate length of stay for an admission. Approval of an admission does not guarantee payment. Please make sure you and your provider confirm your coverage and limitations.

Medical necessity

A service that you receive from a medical provider must be medically necessary, or a specified preventive service, in order to be payable under your health care plan. The guidelines for determining medical necessity are specified in detail in the "Glossary of health care terms" section of this handbook.

In some cases, you are required to pay for services even when they are medically necessary. These limited situations are:

- When you do not inform the hospital that you are a Blue Cross member either at the time of admission or within 30 days after you are discharged
- When you fail to provide the hospital with information that identifies your coverage

Preadmission testing

Preadmission testing is covered within seven days of a scheduled admission or surgery when received in a hospital outpatient department. These tests must be valid at the time of the admission and must not be duplicated during the hospital stay.

Presurgical consultation

A presurgical consultation from a second physician can help you get additional information about the benefits and risks of your proposed surgery and inform you of any alternative treatments that may be available. X-rays and laboratory services your doctor may request will be covered according to the level of benefits outlined in this handbook.

The physician's recommendation does not affect the approved amount for the surgery. Whether or not the recommendation from the second physician favors surgery, the final decision about the surgery is yours.

Inpatient consultations

In complicated situations, the physician in charge of your case may consult with another physician for assistance or advice about diagnosis or treatment. Inpatient consultations are covered when they are requested by the attending physician.

Surgery

Surgical procedures needed for the diagnosis and treatment of disease and injury are covered. Surgical benefits include all related pre- and post-operative medical care by the attending surgeon.

Multiple surgeries

Two or more surgical procedures performed during one operative session are subject to payment limitations:

- When the surgeries are through **different** incisions, your coverage pays the approved amount for the primary surgery (the procedure with the higher benefit payment), plus half of the approved amount for any additional procedures.
- When the surgeries are through the **same** incision, your coverage pays the approved amount only for the primary surgery. Physician payment is included in the amount paid for the primary surgery.

➢ **Note:** Participating providers accept our approved amounts as payment in full, less any required deductible, coinsurance and copayment.

Other surgeries

- **Laser surgery** is covered when the procedure is not considered experimental or investigative, and the payment is not more than the cost allowed for a conventional surgical procedure.
- **Breast reconstruction surgery is covered for**:
  - Reconstruction of the breast following a mastectomy
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas
- **Cosmetic or reconstructive surgery** is covered only for correction of birth defects, conditions resulting from accidental injuries or traumatic scars and correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Dental surgery** for the removal of impacted teeth or multiple extractions is covered only when the patient must be hospitalized for the surgery because a concurrent medical condition exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.
- **Voluntary sterilization** is covered regardless of medical necessity.

Gender Dysphoria Treatment

Blue Cross covers medically necessary services for the treatment of gender dysphoria. This includes professional and facility services and is subject to any applicable copayments and deductibles required by your coverage.

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 Behavioral/Mental Disorders (DSM).

Gender Transition Services

A collection of services that are used to treat gender dysphoria. These services may include hormone treatment and/or gender transition surgery, as well as counseling and psychiatric services. These services must be medically necessary to be payable by Blue Cross.

We do not pay for:

- Gender transition services that are considered by Blue Cross to be cosmetic, or treatment that is experimental or investigational.

Technical surgical assistance

Surgical assistance provided by another physician when requested by an operating surgeon is covered. It is payable only when an intern or hospital physician is not available for assistance. The surgery requiring assistance must be an approved major surgical procedure.

Room and board

Your benefits include the cost of a semi-private room, use of special units such as intensive, burn, or cardiac care; meals and special diets; and general nursing care. However, the cost of a private room

is not covered unless that is standard for that facility. If you request a private room, your coverage will pay the cost of a semi-private room, and you must pay the difference.

General medical care

You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. The following types of admissions are considered general medical care:

- **Cosmetic surgery** — Admissions for cosmetic and reconstructive surgery are covered for the correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.
- **Dental surgery** — Admissions for dental surgery are covered for the removal of impacted teeth or multiple extractions **only** when a concurrent hazardous medical condition, such as a heart condition, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Hospital services and supplies

The following services and supplies are covered when they are needed during an admission:

- **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist or by a certified registered nurse anesthetist or by a nurse anesthetist under the supervision of an anesthesiologist when billed as a hospital service
- **Blood services** — Includes blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service
- **Drugs** — Includes medicines prescribed and given during an admission
- **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay
- **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the admission
- **Prosthetic and orthotic appliances** — Includes items that are surgically implanted in the body, such as heart valves
- **Special care units** — Includes operating, delivery and recovery rooms

Your coverage includes the following diagnostic and radiology services:

- **CAT and MRI scans** — Covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by Blue Cross
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an illness or injury

Outpatient care

The following services are covered when received in the outpatient department of a participating hospital, doctor's office, or, where noted, in a freestanding facility approved by Blue Cross. All benefits are subject to any deductibles, coinsurances, copayments or benefit maximums. A service that you receive from a medical provider must be medically necessary, or a specified preventive service, in order to be payable under your health care plan.

Outpatient surgery care

Your coverage includes surgical services performed in an outpatient surgery facility. This generally includes elective surgery that does not require the use of hospital facilities but cannot routinely be performed in an office setting.

Home health care

Your benefits include home health care visits when the patient is referred to and accepted by a participating home health care agency. The services must be prescribed by a physician who sends a detailed care plan to the home health care agency and certifies that home health care is medically necessary.

Home health care benefits include nursing services, physical, occupational or speech therapy, social service and nutritional guidance, medication, supplies and lab work.

Skilled nursing care

A convalescent care facility provides skilled, comprehensive inpatient care for either a short or extended period of time. Your coverage includes skilled nursing care in an approved skilled nursing facility, when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. Physician benefits for medical care are limited to two visits per week.

Convalescent care benefits cannot be used for custodial care or care for behavioral/mental deficiency, behavioral/mental retardation, senile deterioration or cases in which the prognosis is unfavorable.

Private duty nursing

Private duty nursing is covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Nonskilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

The services must be prescribed by a physician and provided by a registered nurse or licensed practical nurse. The attending physician must complete a certification statement each month the patient is under care. Services are intended to be temporary with the goal of training caregivers to provide the necessary services as competently, independently, and completely. Prior authorization is required.

Cardiac rehabilitation

You have coverage for cardiac rehabilitation services. This benefit is payable if it is provided:

- In a hospital-based or freestanding (not owned or operated by a hospital) cardiac rehabilitation center
- By a licensed physician or professionals working under the direct supervision of a licensed physician
- Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery
- For physician-prescribed exercises to cardiac patients during phase II of their cardiac rehabilitation treatment
- Within the 12 week total time allowed for cardiac rehabilitation

Cardiac rehabilitation

Cardiac rehabilitation services include:

- A six-week program that follows inpatient admission or outpatient services for a heart condition
- Complete medical history
- Stress test with electrocardiogram monitoring
- Lipid profile
- ECG
- Three exercise sessions per week
- Nutrition and risk factor recognition classes

➢ **Note:** Patient education services and ECG testing are not covered as separately identifiable services when reported as part of cardiac rehabilitation.

Hemodialysis

Hemodialysis services to treat acute renal (kidney) failure and end-stage renal disease are a benefit. Treatment may take place in the outpatient department of a hospital, in a licensed facility or in the home. Home hemodialysis must be arranged by a physician and services must be billed by a participating hospital that has an approved hemodialysis program. Coverage includes the cost of the equipment, installation, training and necessary hemodialysis supplies.

➢ **Note**: Dialysis services for the treatment of End Stage Renal Disease are coordinated with Medicare. It is important for individuals with ESRD to apply for Medicare coverage regardless of age. Blue Cross is the primary payer for up to 30 months if the member is under 65 and is eligible for Medicare solely because of ESRD.

Home Hemophilia Program

The Home Hemophilia Program provides benefits for the necessary medications and supplies used to treat hemophilia in a home setting. All medications and supplies needed for the patient to self-infuse at home, including syringes, needles and the antihemophilic factor, must be supplied by a

participating hospital. Benefits may also include training to the patient or a family member on how to inject the antihemophilic factor, when the training is provided through a participating hospital. Services are coordinated through the Individual Case Management Program and may not be subject to deductibles, coinsurances and copayments.

Chemotherapy

You may receive chemotherapy treatment in a hospital, in the outpatient department of a hospital or in a physician's office.

Benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy and provided as part of a chemotherapy program, and if the treatment is not considered experimental or investigative. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

Diagnostic and radiation services

All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

- **Diagnostic radiology** — Benefits include outpatient diagnostic radiology services required for the diagnosis of an illness or injury when performed and billed by a physician. These services may be performed in the physician's office or in the outpatient department of a hospital. Covered services include ultrasound and diagnostic X-rays. MRI and CAT scans of the head and body also are covered when performed for an eligible diagnosis in approved facilities. Select services may require prior authorization.
- **Laboratory and pathology services** — Laboratory and pathology services performed in the physician's office or in the outpatient department of a hospital and ordered and billed by a physician are covered. This benefit includes laboratory and pathology tests required in the diagnosis of an illness or injury.
- **Diagnostic tests** — Diagnostic tests performed in the physician's office or in the outpatient department of a hospital are covered when performed and billed by a physician. Covered tests include EKGs, EMGs, EEGs, thyroid function tests, select sleep studies and nerve conduction studies required in the diagnosis of an illness or injury. Select services may require prior authorization.
- **Radiation therapy** — Radiation therapy performed in a physician's office or in an outpatient department of a hospital is covered when performed and billed by a physician. Covered services include radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

Hospice care

A hospice is an agency or facility that is primarily involved in providing care to terminally ill patients. A patient is considered terminally ill when their attending physician has certified in writing that life expectancy is six months or less.

Hospice benefits take the place of benefits normally available under your medical coverage and add benefits that are more specific to the patient's needs. Services for medical conditions unrelated to the terminal illness are subject to medical coverage guidelines.

You may apply for hospice benefits only after a discussion and referral by your attending physician. All hospice services must be arranged through an approved hospice provider.

Levels of care

The hospice program provides four levels of care:

- **Routine home care** — Services provided to patients who are living at home and are not receiving continuous home care. Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.
- **Continuous home care** — Nursing care services provided to patients during crisis periods to enable them to stay in their homes. Such care must be provided for a minimum of eight continuous hours per day.
- **Inpatient respite care** — Short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in an approved facility on a nonroutine or occasional basis and in increments of five days or less in any 30-day period.
- **General inpatient care** — Services for pain control and acute and chronic symptom management that cannot be provided in other less intensive settings.

Additional benefits

Your coverage pays the allowed amount for the following additional benefits. All benefits are subject to deductibles, coinsurances, copayments or benefit maximums.

Pain management

BCBS considers pain management an integral part of a complete disease care plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases. Your health care benefits provide for this coverage and are subject to contract limitations.

Prescription drugs under medical coverage

In certain situations, prescription drugs are covered as part of your medical benefits.

Medical drugs administered by a physician are covered as follows:

- Injectable and infused drugs — Blue Cross covers these drugs and their administration when:
  - The drug or biological is FDA approved.
  - The drug is ordered or supplied by a physician, and the drug is administered by the physician or under the supervision of a physician.
  - All necessary prior authorizations have been obtained. Not all drugs require prior authorization.

Prior authorization for medical drugs

Blue Cross requires prior authorization for the administration of select medical drugs. These include medical drugs administered in:

- A health care provider's office
- Clinic settings
- Patient's home
- Outpatient facilities*

Prior authorization is required for medical drugs received anywhere in the United States. Your doctor must contact Blue Cross and follow our approval process prior to administering the medication. Blue Cross will notify your doctor of the approval.

Only FDA-approved drugs can be preauthorized, and Blue Cross will preauthorize only those medical drugs that meet our medical policy criteria for treatment of your condition.

*Some preauthorized medical drugs have a site of care requirement. As part of the prior authorization process, the location where the drug is administered is reviewed with the need for the drug. The site of care may require that you receive the medical drug in a doctor's office, your home or a freestanding clinic rather than an outpatient facility.

- If your physician asks for prior authorization and Blue Cross doesn't grant it, you have the right to appeal under applicable law. If the prior authorization is not approved following the appeal process, you will be responsible for the full cost of the medical drug.
- If your physician does not get prior authorization, Blue Cross will deny the claim and you will be responsible for the full cost of the medical drug.
- If your physician did not get prior authorization and you appeal the denial of the claim, Blue Cross will review the claim to determine if the benefits can be paid. If Blue Cross upholds the denial, you have the right to appeal under applicable law.

Note: If Medicare is your primary insurance coverage, your physician does not have to get prior authorization from Blue Cross, but may still need approval from Medicare.

Standard Diabetic Supplies and Devices

You have coverage for select diabetic supplies and devices when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors, Test Strips for Glucose Monitors, Test Strips and Lancets, Continous Glucose Monitor Sensors and Insulin Delivery Resevoirs.

Diabetic supplies are subject to your preferred brand-name drug and/or non-preferred brand-name drug cost share requirement.

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

Allergy services

Allergy testing and therapy are covered when performed by or under the supervision of a physician. Services include scratch and puncture testing, allergy survey, allergy serum and therapeutic injections.

Chiropractic services

Your benefits include the following chiropractic services:

- **New patient office calls** — Covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office visits**
- **Chiropractic traction** — Number of payable visits is determined by your physical therapy benefit.
- **Chiropractic manipulation**
- **Physical therapy**
- **X-rays**
- **Spinal manipulation**

Oxygen and other therapeutic gases

Oxygen and other therapeutic gases and the equipment needed to administer them are covered when medically necessary and prescribed by a physician.

Prediabetes management solution

For people who are at risk for diabetes, weight management and lifestyle changes can help you avoid diabetes and get you on the track to better health. Blue Cross Blue Shield of Michigan, working with Teladoc Health, is able to offer you a program that does just that. Through use of technology, personal coaching and strategies for healthy living, everyone can be encouraged to make small changes that result in big wins. Whether it's the use of a cellular-connected scale to make weigh-ins easier or one-on-one sessions with expert coaches, this program will help you get and stay healthy. For more information on this program, go to our website at **bcbsm.com**.

Diabetes management solution

If you have diabetes, you know how important it is to manage your condition so that you can avoid complications. Blue Cross Blue Shield of Michigan is working with Teladoc Health on a program that helps our members by offering a cellular-connected glucose meter which provides real-time feedback following a reading so your blood sugar can be monitored and shared with health care providers and loved ones. In addition, the program offers food and activity tracking and coaching from certified diabetes care specialists. It's a convenient and simple way to make sure that you have the help you need to manage your diabetes. For more information on this program, go to our website at **bcbsm.com**.

Weight management solution

Dealing with weight management can be difficult and it's important to keep it under control so that you can avoid the long-term issues related to it. Blue Cross Blue Shield of Michigan and Teladoc have a program for you that will help you understand the impact of your lifestyle habits on weight management. We provide a smart scale, one-on-one expert coaching and guidance on creating health habits that last.

Hypertension management solution

Dealing with hypertension can be difficult and it's important to keep it under control so that you can avoid the long-term issues related to high blood pressure. Blue Cross Blue Shield of Michigan and Teladoc Health have a program for you that will help you understand the impact of your lifestyle habits on hypertension. By using the free cellular-connected blood pressure monitor, you're able to read your blood pressure at your convenience. Using this information along with food and activity tracking, expert coaches can help you see where diet and exercise habits could help control your high blood pressure. For more information on this program, go to our website at **bcbsm.com**.

Blue Cross Coordinated Care

Blue Cross Coordinated Care is a voluntary program designed to assist you or one of your dependents whose cost of medical care is very high or where care could exhaust available benefits. Blue Cross Coordinated Care surrounds you with a team that connects you to the right care at the right time, so you can focus on your health.

The coordinated care program assigns a registered nurse to work directly with you and your family to coordinate the best care to meet your specific needs. The nurse engages a care team of doctors, social workers, dietitians, specialists and more, as needed, to help you:

- Better understand your condition, medications and treatment options
- Help you find a primary care physician
- Coordinate care with all your health care providers
- Connect with support and services in your local community
- Find behavioral health services and care for other special needs
- Set and reach your health goals
- Track your progress
- Identify health risks and steps you can take to improve your health

If you're identified for the program, a Blue Cross Coordinated Care nurse will contact you. Your nurse heads a care team that includes:

- **Doctors** to provide medical expertise when needed
- **Pharmacists** to educate and advise about the right medications
- **Dietitians** to provide targeted nutritional education and coaching
- **Social workers** to help locate community resources
- **Behavioral health specialists** to help with stress, depression, anxiety and other issues

Your nurse will check in with you regularly to help coordinate care and answer your health care questions. Blue Cross has made it easy for you to stay on track with your care plan with a mobile app powered by Wellframe.* Through the app, you can connect with your care team by text or chat. Use the app on your smartphone or tablet to:

- Chat with your nurse and care team
- Set reminders to track your appointments and medications
- Read helpful articles about your condition
- View a daily list of tasks to complete to help improve your health

If you have any questions about Blue Cross Coordinated Care, call 800-775-2583 Monday to Friday from 8 a.m. - 5 p.m. Eastern time. TTY users call 711.

*Wellframe is an independent company supporting Blue Cross Blue Shield of Michigan by providing care management services.

Durable medical equipment

Benefits cover rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. Examples of durable medical equipment are canes, wheelchairs and walkers.

The equipment must be medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient's body. Equipment primarily for the comfort or convenience of the patient is not covered.

Medical supplies and dressings

Your benefits include medically necessary medical supplies and dressings used to treat a diagnosed condition.

Prosthetic and orthotic appliances

Benefits are provided for external appliances to replace a missing part of the body or to correct any defect of form or function of the body. Benefits include temporary appliances, delivery, services and fitting charges.

These appliances must be prescribed by a physician and supplied by a fully accredited facility approved by the American Board of Certification in Orthotics and Prosthetics.

Adjustment or replacement of eligible appliances is payable only when required because of normal wear or growth or a change in the patient's condition. Examples of these appliances are braces and artificial arms and legs.

Prosthetic appliances following mastectomy

Benefits are provided for an external breast prosthesis following a mastectomy when prescribed by a physician. Benefits cover two post-surgical forms and 2 surgical bras every benefit period. Replacements are payable only when required because of a significant change in body weight or when necessary for hygienic reasons.

Podiatrist services

Your coverage includes routine foot care services for a medically necessary diagnosis.

Dental services

Dental services and appliances required for the treatment of an accidental injury are covered. The injury must have been caused by an external force. Injuries resulting from biting or chewing are not covered unless they are the direct result of an act of domestic violence or a behavioral/mental health condition.

Optical services following cataract surgery

Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.

Temporomandibular joint syndrome or jaw-joint disorder

Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs) and arthrocentesis (injection procedures). However, some symptom-management services are covered, such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications) and medications.

Please note that **irreversible** treatment of the mouth, teeth or jaw is intended to bring about permanent change in the positioning of the jaw or a permanent alteration of the vertical dimension. **Reversible** treatment of the mouth and jaw is *not* intended to result in permanent alteration of the bite; it is directed at managing the patient's symptoms.

Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint and skull and the muscles, nerves, and tissue related to the jaw joint. These exclusions include but are not limited to: crowns, inlays, caps, restorations, grinding, orthodontics, dentures, partial dentures or bridges.

If you are not sure that your prescribed treatment will be covered, ask your physician to contact Blue Cross for approval **before** treatment begins.

Physical, occupational and speech therapy

You have coverage for physical, occupational and speech therapy when received in:

- The outpatient department of a participating hospital
- A participating outpatient therapy facility
- A physician's office
- Physical therapy services are also covered when received from independent, licensed therapists and chiropractors.

➢ **Note:** Payment for therapy is based on the diagnosis and where you receive care. Ask your physician or therapist to call Blue Cross to verify that the treatment meets diagnosis

requirements and if the therapy will be provided in an approved location before you receive any therapy treatment.

Therapy must:

- Be prescribed by the patient's physician
- Require the assistance and supervision of an appropriately licensed therapist
- Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal function due to illness or injury
- Be for a condition capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered therapy are:

- Physical therapy to restore the musculoskeletal function of legs
- Physical therapy used as a treatment to promote the healing of an acute injury or illness involving the muscles or joints
- Speech and language therapy used as treatment for severe congenital or developmental disorders. The disorders must meet the guidelines for assessment of severity or generally accepted standards of practice. Care plans for these conditions must contain measurable goals that providers regularly assess. Progress toward these goals must be documented in the patient's clinical record in order for coverage to continue. (See speech pathology severity guidelines in the "Glossary of health care terms" section.)

Your coverage does not pay for:

- Long-standing, chronic conditions such as arthritis
- Health club membership or spa membership
- Inpatient admissions principally for speech or language therapy

Autism spectrum disorders

We pay for the diagnosis and outpatient treatment of autism spectrum disorders, including: autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as described below.

Diagnostic services must be provided by a licensed physician, licensed psychologist or a board certified licensed behavioral analyst and include: assessments, evaluations, or tests, including the autism diagnostic observation schedule.

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

- Mental health treatment includes evidence-based treatment programs such as applied behavior analysis. Applied behavior analysis services must be provided or supervised by a board-certified behavior analyst or a licensed psychologist so long as the services performed are consistent with the psychologist's formal training and supervised experience.

➢ **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.

Applied behavior analysis services are covered subject to the following requirements:

- **Treatment plan** – Applied behavior analysis services must be included in a treatment plan recommended by a Blue Cross-approved autism evaluation center that evaluated and diagnosed the member's condition. Treatment plan reviews requested by Blue Cross will be covered.
- **Prior authorization** – Applied behavioral/mental analysis services must be approved for payment through our prior authorization process. If approval is not obtained, services are not covered and the member is responsible for payment for those services. Prior authorization is not required for any other covered autism services.

Mental health treatment includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are consistent with the psychologist's formal training and supervised experience.

Psychiatric care includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

Psychological care includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.

➢ **Note**: Benefits for autism disorders are in addition to any psychiatric, psychological, and non-applied behavior analysis benefits that may be available under the plan.

Therapeutic care includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.

Coverage requirements

All autism services and treatment must be:

- Medically necessary
- Comprehensive and focused on managing and improving the symptoms directly related to a member's autism spectrum disorder.
- Deemed safe and effective by Blue Cross.

Limitations and Exclusions

In addition to those listed in this handbook, the following limitations and exclusions also apply:

- Benefits for line therapy (applied behavior analysis treatment) are not subject to a visit maximum.
- Occupational therapy, physical therapy and speech and language pathology services for a diagnosis of autism are not subject to a visit limitation.

- All autism benefits including, but not limited to, medical-surgical services and/or behavioral/mental health treatment covered under this plan are subject to any hospital/medical deductibles, coinsurances and copayments imposed under this plan.
- Any treatment that is not a covered benefit by Blue Cross, including, but not limited to, sensory integration therapy and chelation therapy will not be paid.
- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder are not payable under this plan.
- When a member is treated with approved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in your plan 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.
- All autism services must be provided by professional providers who are registered with BCBS as a participating or non-participating provider.

Transplants

Certain types of human organ transplants are covered when received at a Blue Cross-approved transplant facility. Certain transplant benefits are subject to any deductibles, coinsurances and copayments and benefit maximums of your plan. All transplants must be coordinated through the Blue Cross Transplant Program in order to be covered.

We will not pay benefits for services, admissions or lengths of stay that are not approved in advance.

The approval process allows you and your provider to know if we will cover proposed services, admissions and lengths of stay in a hospital before treatment begins. If approval is not obtained **before** you receive services or are admitted to a hospital, the services, admission and length of stay will not be covered.

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

A decision to approve services, an admission or length of stay will be based on the information your provider submits to us. We reserve the right to request other information to determine if approval is appropriate.

If your condition or proposed treatment plan changes after approval is granted, your provider must submit a new request for approval. Failure to do so will result in the transplant, related services, admission and length of stay not being covered. The designated transplant center must submit its written request for approval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program

Mail Code 504C
600 E. Lafayette Blvd.
Detroit, MI 48226

Fax: (866) 752-5769

For questions, you or your provider can call 800-242-3504

Approval will be granted if:

- The patient is an eligible Blue Cross member
- The patient has Blue Cross hospital-medical-surgical coverage
- The proposed services will take place in a designated transplant center or in an affiliate of a designated center
- The proposed services are medically necessary
- An inpatient admission to a designated transplant center and the length of stay at the center are medically necessary (in those cases requiring inpatient treatment). A request for an admission and length of stay must be approved by Blue Cross before the admission occurs.

The services covered are payable when directly related to a transplant. The transplant must be performed at a designated transplant center or its affiliate to be a covered benefit.

Organ and tissue transplants

Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient when performed in a participating facility. Coverage includes evaluation and surgical removal of the donated organ (including skin, cornea and kidney) from a living or nonliving donor. These transplants are subject to the same guidelines as your other PPObenefits.

Bone marrow transplants

When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition and when preapproved by Blue Cross, the following services are covered:

- **Allogeneic transplants**
- **Autologous transplants**

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices.

For details on what is covered by both types of bone marrow transplants and what conditions are covered, please contact the Transplant program.

Oncology clinical trials

Oncology clinical trials cover bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all

stages of ovarian cancer when they are provided as part of an approved phase II or III clinical trial. This does not limit or preclude coverage of antineoplastic drugs when state law requires that these drugs, and the reasonable cost of their administration, be covered.

For details on what is covered under oncology clinical trials and what conditions are covered, please contact the Transplant program.

Specified human organ transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full less any applicable deductible, copayment or coinsurance required by your plan when the transplant is preapproved by Blue Cross and received at a Blue Cross-designated transplant facility.

Benefits apply only to transplants of the:

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

All payable specified human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

For details on what is covered by specified human organ transplants and what conditions are covered, please contact the Transplant program.

Mental Health and Substance Use Disorder Treatment

Your coverage includes services to treat behavioral/mental health issues as well as substance use disorders. It can include both outpatient counseling and inpatient treatment at approved facilities. Inpatient and select outpatient services require prior approval. Most outpatient behavioral/mental health/substance use disorder therapy and counseling sessions do not require prior approval.

What is required to receive inpatient mental health and substance use disorder treatment services?

1) Be aware that an authorization is required before you receive certain inpatient behavioral/mental health and substance use disorder services.
2) Your doctor is aware of this authorization requirement and will contact the Blue Cross behavioral/mental health and substance use disorder treatment administrator, to submit the

request. This administrator will either authorize or deny the services requested. If services are denied, you will receive clear instructions on what happens next or if more information is needed.

Blue Cross requires authorization for the following mental health and substance use disorder services:

- Inpatient facilities for mental health or substance use disorder treatment
- Residential facilities for mental health or substance use disorder treatment
- Partial hospitalizations

If you have benefit or claims questions, call customer service at the number on the back of your ID card. For questions on mental health or substance use disorder treatment assistance contact 800-762-2382.

Care provided during a mental health and substance use disorder treatment admission can include individual and group therapy sessions and family counseling. Benefits also include care in an Acute Care Hospital and Residential Treatment Facility.

Fully licensed psychologists with hospital privileges can be directly reimbursed for the following inpatient services:

- **Psychological testing**
- **Individual psychotherapeutic treatment**
- **Family counseling** for members of a patient's family
- **Group psychotherapeutic treatment**
- **Inpatient consultations** when your physician requires assistance of a consulting psychologist in diagnosing or treating your behavioral/mental health condition

➢ **Note**: Inpatient mental health care and substance use disorder admissions are covered only if they meet Blue Cross severity of illness and intensity of service criteria. The doctor must call the Blue Cross behavioral/mental health manager to obtain approval for services.

Psychiatric residential treatment

To find out if your benefits cover psychiatric residential treatment, call the Customer Service number on the back of your Blue Cross ID card. If you have the benefit, a customer service representative can help you find a facility. Be sure to ask your doctor or health care professional if psychiatric residential treatment is right for you or your family member. Your doctor can arrange your treatment with the appropriate facility. The facility must obtain authorization for your treatment to be covered.

If your coverage includes psychiatric residential treatment:

Psychiatric residential treatment allows people who are suffering from a psychiatric illness, such as anorexia nervosa, schizophrenia or bipolar disorder, to receive around-the-clock care.

Treatment takes place in a state-licensed facility, for example, an adult or child foster care facility with an integrative treatment team. The facility offers these services to help with psychiatric issues, administration of medication and crisis intervention:

- Patient supervision 24/7
- Nursing care on-site, or on call no more than 15 minutes away, 24/7

- A psychiatrist on call 24/7
- A psychiatrist on-site at least two days each week.

Outpatient mental health care

Your benefits include psychological testing, individual and group therapy sessions and family counseling when provided by an approved facility, by a physician or by a fully licensed psychologist.

If your provider offers Telemedicine visits, these services are also covered.

Outpatient substance use disorder treatment

Your benefits include outpatient substance use disorder treatment provided at an approved substance use disorder treatment facility.

PRESCRIPTION DRUG COVERAGE

This section explains what is covered under your prescription drug coverage.

Prescription drug benefits

Your prescription drug plan will cover clinically appropriate medications on the Custom Drug List. Your health is important, and the goal of Blue Cross is to provide you with safe, high-quality prescription drug therapies while also keeping your prescription drug costs low. To keep pace with the ever-changing prescription drug market the Custom Drug List will be reviewed regularly.

Covered drugs may be dispensed in quantities up to:

- A 30-day supply from a retail pharmacy, including a hospital-based pharmacy in the standard network.
- A 90-day supply from a retail, hospital-based or mail order pharmacy in the maintenance network.
- Certain specialty drugs are limited to a 15-day supply for each refill

Log in to your member account or use the BCBSM mobile app to assist you in locating a maintenance pharmacy near you. Log in to your secure member account at **bcbsm.com** or on the BCBSM mobile app:

- Click on *My coverage*.
- Click on *Prescription*.
- Click on *Find a pharmacy.*

You have coverage for:

- FDA-approved drugs
- Compound medications – **all** ingredients must be approved for the drug to be covered
- Injectable insulin
- Needles and syringes dispensed with injectable drugs
- Contraceptive medications prescribed by a physician
- Diabetic test strips and lancets
- Preventive drugs covered under the Affordable Care Act
- You can get more information on covered drugs on our website at **bcbsm.com/druglists.**

Standard Diabetic Supplies and Devices

- You have coverage for select diabetic supplies and devices when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors, Test Strips and Lancets, Continuous Glucose Monitor Sensors and Insulin Delivery Reservoirs.
- Diabetic supplies are subject to your preferred brand-name drug and/or non-preferred brand-name drug cost share requirement.

- If you receive diabetic supplies and devices paid under your Blue Cross medical plan, your Blue Cross prescription drug plan will not pay for the same diabetic supplies.

Opioid initiative program

When you are prescribed opioids by your provider, please note:

- Blue Cross will limit the initial prescription fill of select opioids to a 5-day supply when the member is new to therapy. Additional refills for these medications will be limited to no more than a 30-day supply per fill.

Retail pharmacy prescription drugs

Your prescription drug coverage helps to ensure that you and your family have coverage for high-quality prescription drugs with minimal out-of-pocket costs. Here are some ways to get the most out of your employer-provided prescription drug plan.

- Use generic drugs. They are made with the same active ingredients and produce the same effects in the body as their brand name equivalents. They are approved by the Food and Drug Administration as safe, effective treatment options and they save you money.
- Take advantage of over-the-counter medications whenever possible.
- Let your doctor know right away if you are having difficulty with your prescription.
- When you use a pharmacy in our network, your prescriptions and refills are covered at 100 percent of the approved amount less any applicable deductible, copayment or coinsurance required by your plan.
- To find a pharmacy in our network log in to your member account or use the Blue Cross app.
- If you go to an **out-of-network pharmacy** (in Michigan or outside of Michigan), you must pay the full cost of each prescription or refill. You, not the pharmacist, will need to send a claim to us to get reimbursed. If the out of-network pharmacy sends the claim to us, it will be rejected. Ask your pharmacist for an itemized receipt and follow the instructions in the “Filing claims” section of the claim form. You will be reimbursed for 80% percent of the approved amount less any applicable deductible, copayment or coinsurance required by your plan.

Home Delivery prescription drugs

Through your prescription drug plan, you can get up to a three-month supply of most prescription drugs delivered right to your door. You’ll typically pay less by getting up to a three-month supply. Home delivery is easy, safe and convenient.

When you use our home delivery service, you can count on:

- Free standard shipping, in a plain weather resistant pouch
- Convenient deliveries to your home or office
- A registered pharmacist available 24 hours a day, seven days a week
- Refill orders placed at your convenience, by telephone or online

There are three ways to transition to a three-month supply and avoid paying more:

- Visit **bcbsm.com** and log in to your secured member account. Click My Coverage, then click Prescription, then Order online.
- Log in to our **BCBSM** mobile app and tap My Coverage, then tap Prescription, then Mail Order.
- Call OptumRx® home delivery pharmacy at 855-811-2223. OptumRx will contact your doctor to get your new three-month supply prescription.

When you fill a prescription through home delivery for the first time, you should receive your medication within five business days after OptumRx home delivery pharmacy receives your completed order.

Generic equivalent drugs

What is the difference between a generic drug and a brand name drug? There's not much difference, except name and price, because FDA approved generic drugs:

Are as safe and effective as brand name drugs and often less expensive

- Are made with the same active ingredients but may differ in color, size or shape
- Are available in the same strength, purity, quality and dosage form as the brand name drug
- Are often manufactured by the same company that makes the brand name drug
- Earn approval from the U.S. Food and Drug Administration and are strictly regulated by the U.S. government
- Are laboratory tested to ensure that the same amount of drug will be absorbed into the bloodstream as the brand name drug

Ask your doctor or pharmacist whether a generic version of your medication is available and would be right for you. For more information on generic drugs, visit **bcbsm.com/pharmacy** and select *How to save money on prescription drugs.*

Brand name drugs

Brand name drugs will be dispensed only under the following conditions:

- The prescriber must write the prescription as "dispense as written," sometimes noted as "DAW." You will pay only your applicable brand-name copay.
- If you request a brand name drug and the prescriber did not write dispense as written (DAW) on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross approved amount for the brand name drug, plus your copayment.

Specialty drugs

Specialty drugs require special handling, consistency in how and when they're taken, and clinical support. Most specialty drugs must have prior authorization to be covered by your plan. Once approved, all you pay is your deductible or copay.

These drugs treat complex, chronic and rare conditions, such as:

- Cancer
- Chronic kidney failure
- Multiple sclerosis
- Organ transplants
- Rheumatoid arthritis

There are Two Ways to Fill Specialty Drug Prescriptions

You can fill prescriptions for specialty drugs at a retail pharmacy, but not all pharmacies will dispense specialty drugs. Call your pharmacy in advance to verify that it can fill your prescription.

Blue Cross also offers mail order service through Walgreens Specialty Pharmacy.

Request that your doctor fax your specialty medication prescription to Walgreens Specialty Pharmacy at **866-515-1356**.

If you choose to order your specialty medication through Walgreens Specialty Pharmacy, you can receive the following support services anywhere in the U.S.

- Personal attention from a patient-care coordinator who will do all the following:
  - Discuss the best way for you to take your medicine
  - Explain possible side effects
  - Help you understand your condition
  - Call to remind you when you need a refill
- Ancillary supplies, if they're appropriate to administer your medication, are free with each new order and then as needed if you request them. These include syringes, alcohol swabs and sharps containers.
- Dedicated customer service staff is available Monday through Saturday at 866-515-1356. Automated ordering and emergency clinical support are available 24 hours a day, seven days a week.
- Online tools – visit the website at **WalgreensSpecialtyRx.com.**

If you have any questions, call the Customer Service phone number on the back of your Blue Cross ID card.

Limited Distribution Specialty Drugs

Some manufacturers limit the distribution of specialty drugs. These drugs (noted on the specialty drug list on our website) are only available through designated pharmacies. Blue Cross members can fill prescriptions for limited distribution drugs through the following pharmacies:

- Accredo at **800-803-2523**
- Onco360° Oncology Pharmacy at **877-662-6633**

- PANTHERx Specialty Pharmacy at **855-726-8479**

To determine which limited distribution location to call for your specialty drug prescription, follow these instructions:

1. Go to **bcbsm.com/pharmacy**.
2. Click on *What are specialty drugs?*
3. Click on the *Specialty Drug Program Rx Benefit Member Guide (PDF).*
4. Find your prescribed specialty medication under one of the three locations listed above.

You can also talk to your doctor about filling prescriptions for exclusive limited distribution drugs.

High-Cost Drug Discount Optimization Program, powered by PillarRx

Blue Cross Blue Shield of Michigan and Blue Care Network are working with PillarRx to offer you copay assistance to reduce your out-of-pocket expenses for certain high cost drugs. This program is designed to use manufacturer dollars to reduce your out-of-pocket costs. A representative from PillarRx will call eligible members to help them enroll. When you use copay assistance, only the amount you pay for the prescription will apply toward your plan's annual out-of-pocket maximum.

Drug Adherence Discount Program, powered by Sempre Health

Our drug adherence discount program is designed to help you to save money on select medications by reducing your out-of-pocket costs when you fill prescriptions as prescribed. Members on an eligible drug will receive a mailer with instructions on how to enroll in the program. Once enrolled, the program uses digital technology such as text messages and emails to remind you to fill medications on time. This program is designed to help you achieve healthy outcomes by helping you to adhere to your medication therapy.

Hemophilia medication

Blue Cross pays for hemophilia factor products when obtained from:

- In-network or out-of-network providers
- Participating providers
- Non-participating providers

Blue Cross also pays for supplies for the infusion of the hemophilia factor. If a participating provider supplies the product, Blue Cross reimburses the provider directly. If you obtain the product from a nonparticipating provider, we will pay you directly the amount we reimburse our participating providers. You will need to reimburse the nonparticipating provider, and you may have to pay the difference between the Blue Cross amount and what the nonparticipating provider charges.

Pharmacy cost-saving programs

The Blue Cross pharmacy initiatives are a series of cost-saving programs that provide additional ways to reduce drug costs. The following is a summary:

- **Prior Authorization/Step Therapy** for targeted drugs requires that clinical criteria must be met before coverage is approved.
- **Dose Optimization** encourages the use of select prescription drugs in once-daily dosage regimens at a lower cost rather than higher-cost multiple daily doses.
- **Brand to Alternate Generic Interchange** encourages the interchange of brand name drugs with less costly generic alternatives.
- **Generic Copay Waiver** is offered when you switch to a generic equivalent of a multi-source brand. It targets brand name drugs that have a generic equivalent already on the market. When you agree to switch, you'll receive a one-time free copay for the generic drug.

  Note: If your plan has a deductible and your deductible has not been met, there will be no copay to waive.
- **Quantity Limits** restrict the dispensing of targeted drugs in quantities inconsistent with FDA-approved labeling for the drugs. Medical necessity authorization is required to dispense quantities that exceed the limit.
- **Off-Label/High Cost Specialty Review** ensures you are using medication as recommended by the FDA **unless** the prescription is written by a pediatric endocrinologist.

ADDITIONAL BENEFITS

This section explains what is covered under hearing coverage.

Hearing Care Coverage

In addition to your medical benefits, you also have coverage for hearing care. These benefits are designed to identify hearing problems and cover the appropriate corrective devices.

Choosing a provider

When you need hearing care, it is important to find out whether or not your hearing care provider participates with Blue Cross Blue Shield. **Benefits are payable when services are received from a participating provider.** Services received from a non-participating provider are also covered.

Call a Blue Cross customer service representative for names of participating hearing providers.

Time limitation

There are time frames for hearing benefits. You can only receive a hearing aid every 36 months. Manual consideration may be offered if the member received significant changes in their hearing loss, prior to the 36 months.

Hearing care benefits

Before you receive your hearing aid, **you must** have a medical examination of the ear performed by a participating board-certified or board- eligible otologist, otolaryngologist or otorhinolaryngologist. **This examination is not a hearing care benefit.** However, if you use a participating provider, this exam may be paid as an office call under your medical benefits if your medical benefits include office calls.

The following services must be received from a participating provider:

Audiometric examination — Measuring hearing ability, including tests for air and bone conduction, speech reception and speech discrimination

Note: The audiometric exam is a covered benefit.

1. **Hearing aid evaluation** — Determining what type of hearing aid should be prescribed to compensate for loss of hearing. Note: For members age 18 and over, a medical evaluation is required only when the initial hearing aid is billed; for members under 18, the medical evaluation is required each time the hearing aid is covered.
2. **Ordering and fitting the hearing aid** — Including in-the-ear, behind-the-ear and basic hearing aids worn on the body, with ear molds, if necessary

3. **Conformity test** — Evaluating the performance of a hearing aid and its conformity to the original prescription after it has been fitted

BENEFIT LIMITATIONS AND EXCLUSIONS

This section explains what is not covered under your benefit plan.

Medical

In addition to the exclusions and limitations listed elsewhere in this handbook, unless otherwise stated, the following exclusions and limitations apply:

- The following amounts or charges may not be used to meet your out-of-pocket maximum:
  - Charges that exceed the approved amount
  - Charges for noncovered services
  - Deductible or coinsurance required under other Blue Cross coverage
- Care and services available at no cost to you in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- Custodial care, rest therapy and care in nursing or rest home facilities
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition, such as a heart condition, exists
- Treatment of temporomandibular joint syndrome and related jaw-joint problems by any method other than as specified in this handbook
- Any medical care, hospitalization or service provided before the effective date of coverage or after the coverage termination date
- Routine hospital outpatient care requiring repeat visits for the treatment of chronic conditions such as diabetes
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests or electrocardiography
- Items for the personal comfort or convenience of the patient
- Psychiatric services after determination that the patient's condition will not respond to treatment
- Psychological tests for vocational guidance or counseling
- Routine premarital or pre-employment exams
- Prescription drugs (may be covered under an additional freestanding program)
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services provided through a medical clinic or similar facility provided or maintained by an employer
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund

- Care and services received under another plan offered by Blue Cross Blue Shield of Michigan or another Blue plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires Medicare to be secondary.
- Cosmetic surgery solely for improving appearance, except as specified in this handbook
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay
- Dialysis services after 30 months of end stage renal disease treatment
- Services that are not included in your employer's coverage documents
- Charges from a nonparticipating provider that are in excess of the Blue Cross approved amount
- Charges for hospital room accommodations over and above the hospital's regular charges covered by your medical benefits
- Transportation and travel except as specified in this handbook
- Hearing exam and preparation, fitting or procurement of hearing aids (may be covered under your hearing care coverage)
- Eyeglasses or contact lenses and vision examinations for prescribing or fitting them (except for aphakic patients) or for soft contact lenses or sclera shells intended for use in the treatment of diseases or injury or as specified following cataract surgery
- Professional fees for injections given by anyone other than a physician
- Injections for cosmetic purposes
- Charges for examinations required by school, camp, licensing or for any other regulatory purpose
- Charges for services rendered during an office visit by anyone other than a physician or under the direct supervision of a physician
- Hospital admission for weight control
- Testing more frequently than necessary
- Dental care and dental appliances except those specified in your coverage
- Reversal of sterilization procedures
- Artificial insemination, in-vitro fertilization or embryo transfer procedures
- Radial keratotomy
- Acupuncture services
- Hair prostheses such as wigs
- Experimental bone marrow transplants

Prescription drugs

Exclusions and limitations that apply to your prescription drug coverage are listed below. These are in addition to applicable exclusions and limitations listed elsewhere in this handbook.

- Non-self-administered injectable drugs
- Administration of drugs or any drug consumed at the time and place of the prescription order
- Refills not authorized by a physician
- Therapeutic devices or appliances, even if prescribed by a physician (for example, support garments regardless of their intended use)
- More than a 30-day supply, except for specified maintenance drugs that are covered for 100-unit doses (retail pharmacy) or retail/mail order prescriptions that are covered for a 90-day supply
- Refills dispensed after one year from the date of the original order
- Prescription drugs prescribed for cosmetic purposes
- Any vaccine given solely to resist infectious diseases (many vaccines are covered under medical benefits)
- Any drug determined by Blue Cross to be experimental or investigational, medical foods, homeopathic or herbal
- Any drug that does not require a prescription
- Drugs or services obtained before the effective date or after the contract ends
- Prescriptions issued by anyone who is not legally authorized to prescribe drugs for human use
- Drugs for which the cost is included in the charge for other services or supplies
- Diagnostic agents
- Any drug or device prescribed for uses other than those specifically approved by the Federal Food and Drug Administration.
- Drugs that are not labeled, "Caution: Federal law prohibits dispensing without a prescription," except for state-controlled drugs
- Covered drugs or services dispensed to a member when such services are benefits under other Blue Cross certificates
- Drugs or services covered by government-sponsored health care programs, such as Medicare or TRICARE

Hearing care

Exclusions and limitations that apply to your hearing care coverage are listed below. These are in addition to the exclusions and limitations listed elsewhere in this handbook.

- Your medical examination to determine possible loss of hearing
- An examination by an audiologist that has not been ordered by a physician specialist
- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months when benefits are renewed
- Repairs and replacement of parts
- Member may be responsible for charges that exceed the cost of a covered aid
- All hearing care services and supplies provided by a nonparticipating provider
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements

MEDICARE AND SUPPLEMENTAL COVERAGE

This section describes the benefits available under your Medicare and Supplemental coverage. This coverage is available only to members who are 65 or older, to persons who have end stage renal disease and to certain disabled persons.

About Medicare coverage

Medicare is a federal health care program designed to provide health care benefits to persons aged 65 and older, to persons who have end stage renal disease, or ESRD, and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you're enrolled in this coverage, you're called a beneficiary.

You become eligible for Medicare when you're 65 (or earlier if you're disabled or have ESRD). If you're eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

Medicare coverage has two parts: hospital insurance (Part A) and medical insurance (Part B). Hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medical insurance helps pay for physician's services and other medical services and items.

The hospital insurance portion is provided at no cost to you. However, you must pay a monthly premium for the medical insurance portion. This premium is adjusted annually. You will be notified of the change before each new year.

Option – Continue your current coverage

You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you don't want to continue.

- Medicare Part A, which covers hospital care, is offered without cost to you. It may provide **additional** benefits to your group coverage.
- Medicare Part B, which covers medical care (such as doctor's fees), also is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

If you delay enrolling for Medicare Part B coverage when you reach 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you're no longer covered by your group plan and ends seven months later.

Supplemental coverage exclusions and limitations

Your Supplemental coverage will not cover:

- Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing and taking medications) at home or in a nursing home

- Intermediate nursing care in a nursing home
- Private duty nursing or skilled nursing care not approved by Medicare
- Physician charges that are more than Medicare's allowed amount
- Injury or sickness covered by workers' compensation
- Admissions or care provided by a government-owned or -operated hospital unless payment is required by law
- Admissions or care received before the effective date of coverage or after the coverage termination date
- Drugs other than prescription drugs provided during your stay in a hospital or skilled nursing facility, dental care, dentures, annual physicals, immunizations, cosmetic surgery, routine foot care and examinations for eyeglasses and hearing aids.

FILING CLAIMS

When you use your benefits, a claim must be filed before payment can be made. If you go to participating providers, you won't have to file claims for medical services because claims are submitted directly to Blue Cross for you. However, if you receive medical services from non-participating providers, or you receive care out of the country, you may be required to file your own claims.

Assignment

Benefits outlined in this document are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights to these benefits. 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 these terms.

How to submit a claim

You should submit your claim as soon as you receive covered services. Generally, if you submit claims beyond the applicable filing limitation, they will be denied. Your provider will file a paper claim for you. The following filing limitation guidelines apply for most claims:

- The approved filing limits for pay-provider claims are six months from date of service for professional claims and 12 months from date of service for facility claims.
- The approved filing limits for pay-subscriber claims are 24 months from date of service.
- One year after the date of purchase for prescription drug claims.

If you need a claim form, contact your employer, visit our website **bcbsm.com** or call a Blue Cross customer service representative. To file a claim, follow these steps:

1. Obtain an itemized statement from the provider that includes the following information:
   - Name of the patient and the subscriber
   - Subscriber ID (located on your Blue Cross ID card)
   - Provider's name and address
   - Provider's federal tax ID number
   - Description of services
   - Diagnosis (nature of illness or injury)
   - Date of each service
   - Dates of admission and discharge (if admitted to a hospital)

   You may include cash register receipts, canceled checks or money order stubs with your itemized receipt, but they may not substitute for an itemized receipt.

Note: If you receive medical services out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and U.S. currency amounts. See the BlueCard – Coverage when you travel information in the "Selecting a health care provider" section.

2. Complete a separate claim for each family member. Multiple services for the same patient may be attached to one claim.
3. Attach all itemized receipts and statements to the claim form. Make sure the subscriber's name and subscriber ID from the Blue Cross ID card are on all receipts and attachments.
4. Review all claims to be sure they are accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign and date each claim. Always keep a copy of your claims and receipts because Blue Cross can't return them to you.
5. Mail all claims to the address shown on the form. If you do not have a claim form, send the itemized receipt to your Blue Cross customer service office. Addresses are listed on the inside front cover of this handbook.

What to do if a claim is denied

If your medical claim was not paid, in whole or in part, your explanation of benefits statement will indicate the reason for nonpayment. You can get more information on how to file an appeal on our website at **bcbsm.com/importantinfo**, under "Important Notices About How Your Coverage Works", click on "Appealing a claims decision" or call Customer Service at the number on the back of your ID Card.

Coordination of Benefits

Coordination of Benefits, or COB, is how health care plans coordinate benefits when you are covered by more than one insurance plan. Your company's health care plan is administered by Blue Cross, but if you or members of your family are covered by another health plan, we need to know so we can coordinate your coverage. If you are covered by more than one insurance plan, COB guidelines (explained below), determine which plan pays for covered services first. You may get a coordination of benefits letter asking you for information about other plans. If you get one, please respond promptly so we can keep our records up to date.

Here's how coordination of benefits works:

The plan that pays first is your **primary plan**. This plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is your **secondary plan**. This plan provides payments toward the balance of the cost of covered services — up to the total allowed amount.

COB makes sure that the level of payment, when added to the benefits payable under another plan, will cover up to the total of the eligible expenses. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

Guidelines to determine which plan is primary and secondary

- If a group health plan does not have a COB provision, then that group health plan is primary.

- If a group health plan does have a COB provision, the plan that covers the patient as the employee (subscriber) is primary and pays before a plan that covers the patient as a dependent.
- If a dependent child is covered under both parents' (or legal guardians') plans, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- For children of divorced or separated parents, benefits are determined in the following order unless a Qualified Medical Child Support Order or divorce decree places financial responsibility on one parent:
  1. Plan of the custodial parent
  2. Plan of the custodial parent's new spouse (if remarried)
  3. Plan of noncustodial parent
  4. Plan of noncustodial parent's new spouse (if remarried)

Note: If custody is not known, then the birthday rule is used to determine the order of benefits for children of divorced, separated or never married parents.

When an employee is the subscriber on multiple group health insurances policies, the following applies:

- If both contracts are either "active employee" or "retired employee," then the group health insurance in effect the longest is the primary plan, and the other contract is the secondary plan. (Note: Refers to coverage supplied by the employer group, not which health insurance carrier has supplied coverage longer.)
- If one contract is "active employee" and one is "retiree/laid-off COBRA," then the "active employee" group is the primary plan and the "retiree/laid-off COBRA" employer group is the secondary plan.
- If the primary plan cannot be determined by using the guidelines above, then the plan covering the dependent child the longest is primary.

Updating COB information — your responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your employer immediately. Please help us serve you better by responding to requests for COB information quickly. We will request updated COB information yearly. If COB information such as cancellation of other coverage, switching other coverage carriers or changes in custody or court-ordered coverage for dependent children is not updated, claims could be rejected inappropriately or incorrect messages could be sent to your health care providers.

If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under your contract for your spouse or dependent children, the claim will be temporarily held. We will send you a new letter of inquiry requesting information about other carriers. When you respond, we will update your record. Your claim will then be processed according to the appropriate COB rules.

Important: If you do not respond to our letter of inquiry within 45 days of its receipt, the claim will be denied due to lack of current COB information. In addition, all other claims for your spouse and dependents will be denied until the COB letter of inquiry is returned.

Specific information about Your COB

Your health plan includes non-duplicative COB payment. This means:

- When your Blue Cross contract is the secondary payer, you remain responsible for the deductible, copays and coinsurance required under your Blue Cross coverage.
- As secondary payer, we will not apply your Blue Cross contract network restrictions (prior authorizations and out-of-network cost share) unless the primary insurer denied benefits for the service.
- As secondary payer, we will cover the difference between the amount the primary insurer paid and the amount we would have paid had we been primary.
- This applies for Blue Cross covered services, only.

Filing COB claims to your secondary carrier

Always have your health care provider submit claims to your primary carrier first. Then have your provider submit a claim for the secondary balance to Blue Cross. If your provider will not submit a secondary claim to Blue Cross, then you can submit the claims as follows:

1. Obtain an explanation of benefits statement from the primary carrier.
2. Ask your provider for an itemized receipt or detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt you received from the provider.
4. Make sure the provider's name and complete address are on your receipts. Also include the provider's tax ID number.
5. Send these items to the appropriate address as indicated on the claim form. If you do not have a claim form, send the itemized receipt to your Blue Cross customer service office. Addresses are listed on the inside front cover of this handbook.

Please make copies of all forms and receipts for your own files, because we cannot return the originals to you.

Subrogation

In certain cases, another person, insurance company or organization may be legally obligated to pay for health care services that Blue Cross has paid. When this happens:

- Your right to recover payment from them is transferred to Blue Cross.
- You are required to do whatever is necessary to help Blue Cross enforce its right of recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse Blue Cross. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.

No-Fault Auto Coverage

If you or your eligible dependents are involved in a motor vehicle accident, payment for medical services will be coordinated between BCBS and your auto insurance carrier as follows:

- Your no-fault auto insurance will be secondary to BCBS coverage.

It is important that you discuss this with your auto insurance company.

GLOSSARY — HEALTH CARE TERMS

Accidental injury — Physical damage caused by an action, object or substance outside the body. This includes strains, sprains, cuts and bruises; allergic reactions, frostbite, sunburn and sunstroke; swallowing poison and medication overdosing; and inhaling smoke, carbon monoxide or fumes.

Accidental dental injury – An external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures, or bone.

Ambulatory surgery facility — A separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Approved amount — The BCBS maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles, coinsurances, copayments and sanctions are deducted from the approved amount.

Approved amount for prescription drugs — Lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) paid to the pharmacy, not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Approved facility — A hospital or clinic that provides medical and other services, such as substance use disorder treatment, rehabilitation, skilled nursing care or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements, and must have been approved as a BCBS provider. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital — A hospital that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by BCBS.

BCBS — Blue Cross Blue Shield

BCBSA — Blue Cross and Blue Shield Association, an Association of independent Blue Cross Blue Shield Plans that licenses individual plans to offer health benefits under the Blue Cross Blue Shield name and logo. The association establishes uniform financial standards but does not guarantee an individual plan's financial obligations.

Blue Cross – Blue Cross Blue Shield of Michigan, a non-profit mutual insurance company and one of many individual plans located throughout the United States committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community based public and subscriber members.

BCBS Drug List – A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the Blue Cross Blue Shield of Michigan Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. The Drug List is also known as a formulary.

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

Benefit Period — When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans. *Example: You may have a health plan with a benefit period of January 1 through December 31*.

Brand name drugs – Prescription drugs that are patent protected. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under a generic name.

Clinical trial — A study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- **Phase I** – A study on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition.
- **Phase II** – A study conducted on a large 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 on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Closed Drug List – Only drugs on this list are covered, making the member responsible for the full cost of any non-covered drug that is dispensed.

COB — Coordination of benefits, a program that coordinates your health benefits when you have coverage under more than one group health plan.

COBRA — Continuation coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Coinsurance — The percentage of the approved amount you are required to pay for covered services.

Copayment— Copayment is a flat dollar amount you must pay for eligible services.

Covered services — Services, treatments or supplies identified as payable in your employer's coverage documents. Covered services must be medically necessary to be payable, unless otherwise specified.

Custodial care — Care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating, taking medicine, etc. This care may be given with or without:

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Care supervised by a physician

Deductible — A specified amount that you pay during each benefit period for services before your plan begins to pay.

Designated cancer center— A site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility — A facility that BCBS determines to be qualified to perform a specific organ transplant.

Designated services – Services that BCBS determines only a non-contracted area hospital is equipped to provide.

Durable medical equipment — Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury. This equipment must be prescribed by a physician.

Emergency first aid — The initial exam and treatment of conditions resulting from accidental injury.

Emergency Medical Condition — Whether a condition is an emergency medical condition does not depend on a particular diagnosis. Instead, it is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the member (or during a pregnancy, the health of an unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant member who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the member or unborn child)

Emergency Services — Emergency Services include medical screening exams that are within the capability of an emergency room department of a hospital or independent freestanding emergency departments and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment to stabilize the member. In nonparticipating hospitals and independent freestanding emergency departments, services rendered after the member is stabilized will continue to be emergency services until the member receives and signs a notice and consent form as required under the No Surprises Act.

ESRD — End stage renal disease, permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Experimental or investigative — A service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. BCBS makes this determination based on a review of established criteria such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the BCBSA or other local or national bodies

Fourth quarter deductible carry-over – Any amount applied to the deductible during the fourth quarter months (October, November and December) will be carried over to the next year's deductible.

Freestanding facility — A facility separate from a hospital that provides outpatient services, such as substance use disorder treatment, rehabilitation, skilled nursing care or physical therapy.

Generic drugs – Non-brand name drugs that produce the same effects in the body as the equivalent brand name drugs. The Food and Drug Administration requires that generic drugs have the same active ingredients as the equivalent brand name drugs. They may differ from brand name drugs in color and shape. Since the major difference between brand name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate. They also require the lowest copayment, making them the most cost-effective option for the treatment.

Hospital — A facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Maintenance Pharmacy — A pharmacy contracted with BCBSM to dispense a 90-day supply at retail locations. Standard pharmacies can only dispense a 30-day supply. Pharmacies can be listed as both a maintenance and standard pharmacy.

Medically necessary — A service must be medically necessary in order to be payable by your health care coverage. Medically necessary **hospital services** are those that are:

- For the treatment, diagnosis or symptoms of an injury, condition or disease
- Appropriate for the symptoms and consistent with the diagnosis
- Not mainly for the convenience of the member or health care provider
- Not generally regarded as experimental or investigative by BCBS

Medically necessary physician services are determined by physicians acting for their respective provider types and medical specialty, and are based on criteria and guidelines developed by physicians and other professional providers. Medically necessary physician services are those that are:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.
- Determined by a physician or professional review according to generally accepted standards and practices, in the absence of established criteria.
- Based on standards of practice established by physicians, for BCBS payment purposes.

Medicare — Pays health care costs for eligible persons age 65 or older. Also pays for people younger than 65 diagnosed with end stage renal disease or entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.

Member — Any person eligible for health care services under your plan. This includes you as the subscriber and any of your eligible dependents listed in BCBS membership records.

Network pharmacies — Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx (in Michigan) or our contracted pharmacy benefit manager (outside Michigan) networks. Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Non-Preferred Brand (Tier 3) – The tier 3 drug list contains brand name drugs not included in the Preferred Brand tier. Members pay the highest copayment for these drugs under a triple-tiered plan. Non-Preferred drugs are not covered under a Closed Drug List plan.

Out-of-area hospital — A BCBS 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-network pharmacies — Pharmacies that are not a member of the Preferred Rx (in Michigan) or our contracted pharmacy benefit manager (outside Michigan) networks. Out-of-network

pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

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

PCP - Primary Care Physician specialties include; Clinic Multi-Specialty, Family Practice, General Practice, Gynecology, Obstetrics & Gynecology, Internal Medicine, Pediatrics, Physician Assistant, Urgent Care, Registered Nurse Clinical Specialist, Retail Health Center, Certified Nurse Practitioner, Nurse Practitioner, Family Medicine and Preventative Medicine, unless otherwise noted.

Per claim — A provider's acceptance of the BCBS approved amount as payment in full for a specific claim or procedure.

Physical therapy — Treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Note: Physical therapy is not covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).

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 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
- Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).

Speech therapy — Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Physician - A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners."

Preapproval — A process that allows you or your health care provider to know if we will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services, they will not be covered.

Preferred Brand (Tier 2) – The Tier 2 drug list includes brand name drugs from the Custom Drug List. Preferred Brand options are also safe and effective, but require a higher copayment.

Preventive Care - Care designed to maintain health and prevent diseases or conditions at an early stage when treatment is likely to work best. Examples of preventive care include screenings, mammograms, and colonoscopies.

Professional provider — A medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery, doctor of medical dentistry, chiropractor, clinical licensed master's social worker, licensed professional counselor (LPC), oral surgeon, a fully licensed psychologist or other provider as identified by Blue Cross. Professional providers may also be referred to as "practitioners."

Provider — A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

- **Network providers** – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with BCBS to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept our approved amount as payment in full for covered services.
- **Out-of-network, participating providers** — Providers who are not part of the BCBS PPO provider network. Out-of-network, but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not a part of the PPO network, you must pay higher out-of-pocket costs.
- **Out-of-network** — Providers who are not part of the BCBS PPO network. Medical services received from any physician or hospital that is not part of the PPO network are covered and are subject to higher out-of-pocket costs (except for approved emergencies and referrals).
- **Out-of-network non-participating providers** – Providers who have not signed participation agreements with BCBS agreeing to accept our payment as payment in full.
- **Non-Participating providers** — Providers who have not signed participation agreements with BCBS agreeing to accept the BCBS payment as payment in full. However, non-participating professional providers may agree to accept the BCBS approved amount as payment in full on a per claim basis.
- **Participating providers** — Providers who have signed agreements with BCBS to accept the BCBS approved amount for covered services as payment in full.

Qualified Medical Child Support Order— A court order or court-approved settlement agreement that provides for health benefits for a child of a group health plan participant or enforces one of the mandatory provisions of state law regarding the provision of health insurance to minors in such cases. A QMCSO gives the child the same rights as an employee to receive benefits under a group health plan.

Routine service — Procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

Skilled nursing facility — A facility that provides convalescent and short- or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Speech Pathology Severity Guidelines for Developmental Conditions — Severity criteria for developmental conditions are met when any of the following clinical situations are documented in the patient's medical record:

- The child's condition is scored within the severe range on a standardized test of communicative dysfunction.
- The child's condition is scored within the severe range on a subtest of a standardized test of communicative dysfunction.
- The child is functionally non-verbal at the age of 2.5 years or older.
- The child tests at more than one year behind norms for receptive language on a standardized test of communicative dysfunction.
- The child tests at more than one year behind norms for expressive language on a standardized test of communicative dysfunction.

- The child tests at more than one year behind norms for articulation proficiency on a standardized test of communicative dysfunction.

The medical chart must demonstrate specific treatment goals based on the original and ongoing assessment of the child's speech and language disorder. Measurement of progress toward those goals must be documented.

If a child's severity status changes, as a consequence of treatment, while therapy is in progress, coverage will continue for the remainder of the treatments, depending on the contract limitations.

Subscriber — The employee or COBRA qualified beneficiary who signed the enrollment form for BCBS coverage.

Substance use disorder — Taking alcohol or other drugs in amounts that can:

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

Surprise Billing – See Surprise Billing in the Selecting a health care provider section for more about laws that protect you from surprise billing.

USERRA — A Department of Defense health care program for members of the uniformed services and their families. This includes members of the reserves and National Guard who are called to active duty and their families.

We, us, our – Used when referring to BCBS.

You and your – Used when referring to any person covered under the subscriber's contract.

GROUP NAME: County of Oakland

DIVISION CODES: 2000, 2100, 2200

PACKAGE CODES: 040, 050

EFFECTIVE DATE: 01/01/2025

REVISION DATE: 03/14/2025

CF 0775 AUG 16 R065038

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.
Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles.
Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

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

ܬܘܕܥܐ: ܐܢ ܐܢܬܘܢ ܡܫܡܠܝܢ ܥܪܒܝܐ، ܠܟܘܢ ܫܪܘܬܐ ܕܠܫܢܐ ܕܠܝܬܗ ܕܬܘܡܟܐ ܕܬܘܡܝܐ ܕܝܠܟܘܢ ܕܠܐ ܡܬܚܝܒܐ ܠܡܬܚܠܦ ܥܠ ܫܘܡܐ ܕܝܠܟ. ܐܦܠܘ ܠܡܬܚܝܒܐܝܬ ܬܘܬܒܐ ܠܫܝܡܬܐ ܕܡܬܬܚܘܢ ܒܦܘܪܡܐ ܡܬܐܝܡܢܐ ܠܡܫܡܫܐ ܒܚܢܡ، ܦܢܝܐ ܠܟܘܢ ܠܐ ܡܚܝܒܐ. ܡܨܛܦܘ ܠܘܬ ܡܬܢܝܐ 877-469-2583 TTY: 711 ܐܘ ܡܬܡܝܠܘܢ ܥܡ ܡܙܘܕܐ ܕܡܫܡܫܬܐ ܕܝܠܟ.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다.
877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie
877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination is against the law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 888-605-6461, TTY: 711
Fax: 866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website
https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/