

**Member Handbook  
for retirees of**

**MICHIGAN STATE  
UNIVERSITY**

**Traditional Guide**

**Comprehensive Major Medical  
Preferred Provider Organization (PPO)**



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Dear Subscriber:

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

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

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

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

Sincerely,



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

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## How to Reach Us

**This section lists phone numbers and addresses to help you get information quickly. You may call or visit our BCBSM Customer Service center.**

### To Call

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 p.m. to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

**Area code 248, 313, 586, 734, 810 or 947**

Southeast Michigan toll-free ..... 1-877-790-2583

**Area code 231, 269 or 616**

West Michigan toll-free ..... 1-800-972-9797

**Area code 517 or 989**

Central Michigan toll-free..... 1-800-258-8000

**Area code 906**

Upper Peninsula toll-free ..... 1-800-562-7884

### To Visit

**BCBSM Customer Service centers are located throughout Michigan. Check the following list to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m. You may also visit our website at [bcbsm.com](http://bcbsm.com).**

**Detroit**

500 E. Lafayette Blvd., Detroit 48226  
Downtown, three blocks north of Jefferson at St. Antoine

**Flint**

4520 Linden Creek Parkway, Suite A, Flint 48507

**Grand Rapids**

86 Monroe Center N.W., Grand Rapids 49503

**To Visit**  
(continued)

**Holland**  
151 Central Ave., Holland 49423

**Lansing**  
232 S. Capitol Ave., Lansing 48933

**Marquette**  
415 S. McClellan Ave., Marquette 49855  
Up on the hill

**Portage**  
8175 Creekside Dr., Suite 100, Portage 49024

**Southfield**  
20500 Civic Center Drive, Southfield 48076

**Traverse City**  
City Centre Plaza  
202 State St., Traverse City 49686

**Utica**  
6100 Auburn Road, Utica 48317  
Diagonally across from the AAA Building

## **About Your Benefits**

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

- **A Table of Contents** - for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **Coverage for Hospital, Facility and Alternatives to Hospital Care**
- **Coverage for Physician and Other Professional Provider Services**
- **Coverage for Other Health Care Services**
- **General Conditions of Your Contract**
- **The Language of Health Care** - explanations of the terms used in your booklet
- **How to Reach Us**

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

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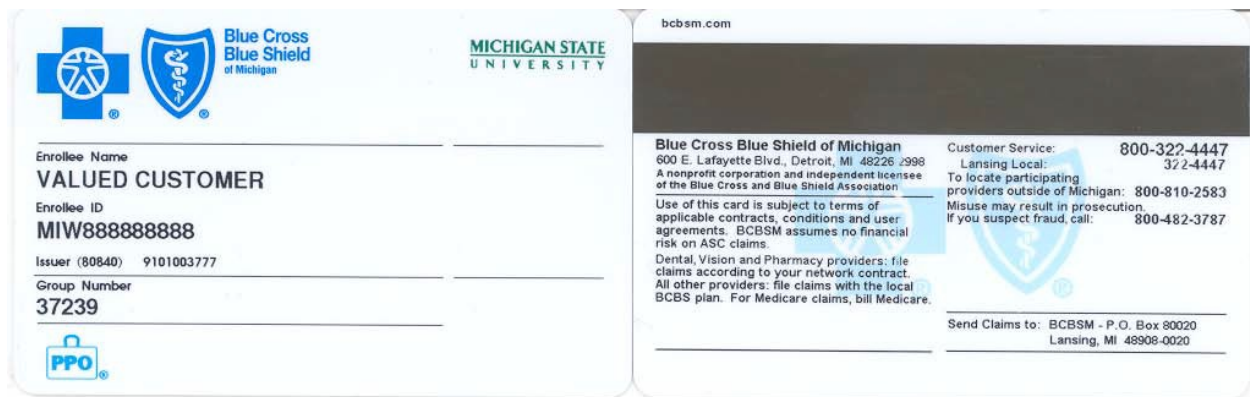
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## General Information

### Your Identification Card

Your BCBSM ID card is your key to receiving quality health care benefits. Your card will look similar to the one below.



The numbers on your personal ID card will be different from the one illustrated above.

- Line 1:** **Enrollee Name** is same as subscriber. All communications are addressed to this name.
- Line 2:** **Enrollee ID** is your assigned identification number.  
The Alpha Prefix (MIW) identifies you as a Michigan Blue Cross Blue Shield of Michigan member.
- Line 3:** **Issuer number** (80840) identifies that Blue Cross Blue Shield is a health insurance carrier, and the number (9101003777) identifies BCBSM as the issuer of the card.  
The suitcase shows that you belong to the BlueCard PPO program, which means you are covered where you live and where you travel.
- Line 4:** **Group Number** identifies the segment of you group's health plan to which you belong.

Your BCBSM ID card is issued once you enroll for coverage. It lets you obtain services covered under your health care plan. Only the subscriber's name appears on the ID cards. However, the cards are for use by all covered members on your contract.

Here are some tips about your ID card:

- Carry your card with you at all times to help avoid delays when you need medical attention.

- 
- Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.
  - Call us if your card is lost or stolen. You can still receive services by giving the provider your contract number to verify your coverage.
  - If you or an eligible family member need a card, please call the customer service number in Section 1 for assistance.

You can request a new or additional ID card online at **www.bcbsm.com**. Log in to ***Member Secured Services*** (registration is required) and click ***Manage my plan***.

Providers may ask for identification other than the BCBSM ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

You can also help prevent fraud by checking Explanation of Benefit Payments (EOBP) statements. If you see a discrepancy on your EOBP, contact your provider first to see if it is an error. If it is not and you believe it is fraudulent billing or use of your card, then let us know by calling our Anti-Fraud Hotline at **1-800-482-3787**. The hotline is open Monday through Friday from 8:30 a.m. to 4:30 p.m.

## **Section 1: Information About Your Contract**

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

- **ELIGIBILITY**
  - End Stage Renal Disease (ESRD)
- **CANCELLATION**
  - Automatic Cancellation
  - Rescission
- **CONTINUATION OF BENEFITS**
  - Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Individual Coverage

**ELIGIBILITY**

Michigan State University is responsible for determining eligibility. BCBSM does not make eligibility determinations, but updates its files to record eligibility information provided by Michigan State University. Please contact the MSU Human Resources for eligibility information.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, that dependent may be eligible for his or her own contract. However, we must be notified within 30 days of the change in order to provide continuous coverage.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.
- You or your dependent becomes eligible for premium subsidies.

You must notify your employer or group if there is a change in your family such as birth, divorce, death, etc. MSU Human Resources must receive notice from your employer or group within 30 days of the change so that any contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

**End Stage Renal Disease (ESRD)**

We will coordinate our payment with Medicare for all covered services used by members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, a participating freestanding ESRD facility or in the home.

When Medicare Coverage Begins

## Section 1: Information About Your Contract

---

For members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.

**Example:** Dialysis begins February 12. Medicare coverage begins May 1.

## ELIGIBILITY

**End Stage Renal Disease (ESRD)** The period before Medicare coverage begins (up to three months) is the Medicare waiting period.  
(continued)

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

### When BCBSM Coverage is the Primary or Secondary Plan

If your BCBSM group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your BCBSM coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, BCBSM is your secondary plan and Medicare is your primary plan.

### Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

## ELIGIBILITY

- End Stage Renal Disease (ESRD)** (continued)
- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

**Example:** You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2012, and on Sept. 1, 2012, you become entitled to Medicare because you have ESRD. In February 2013 you become entitled to Medicare because you turn 65.

In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from Sept. 1, 2012, through February 2015. Your employer's plan will be your secondary plan starting March 1, 2015.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:
  - If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period.

**Example:** You became entitled to Medicare in June 2012, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2014, you are diagnosed with ESRD and begin a regular course of dialysis. On Aug. 1, 2014, you become entitled to Medicare because you

## ELIGIBILITY

### **End Stage Renal Disease (ESRD)** (continued)

have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from Aug. 1, 2014, through Jan. 31, 2017. Medicare becomes your primary plan on Feb. 1, 2017.

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

**Example:** You retired at age 62 and continued your coverage through your employer as a retiree. In August 2012, when you turn 65, you become entitled to Medicare. In January 2013 you begin a regular course of dialysis. On April 1, 2013, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

## CANCELLATION

### **Automatic Cancellation**

We will automatically cancel your coverage if:

- Your group does not qualify for coverage under this certificate
- If the group fails to reimburse BCBSM according to the terms of the contract.

## CANCELLATION

### **Automatic Cancellation** (continued)

We will automatically cancel your coverage if: (continued)

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

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

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

Your coverage will end on the last day covered by the last payment made by your group, employer, or remitting agent. However, if you are an inpatient at a hospital or facility on the date your coverage ends; please see the General Condition “Services Before Coverage Begins or After Coverage Ends” in Section 6.

## **CANCELLATION**

### **Rescission**

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

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

## **CONTINUATION OF BENEFITS**

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

COBRA is a federal law that affects most employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60 days of the qualifying event or the date the COBRA notice is sent by the plan administrator, whichever is later. It provides the following coverage at the covered member's expense:

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

## CONTINUATION OF BENEFITS

**Consolidated  
Omnibus  
Budget  
Reconciliation  
Act (COBRA)**  
(continued)

COBRA coverage can be terminated because:

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

**Please contact your employer for more details about COBRA.**

**Individual  
Coverage**

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

**To Change Your  
Address**

If you change your address, or if your address is incorrect in our records, please notify MSU Human Resources promptly. This will ensure that you will continue to receive any notices BCBSM sends to you.

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## Section 2: What You Must Pay

**This section explains the deductible and copayments you must pay each calendar year.**

### **Deductible Requirements**

You are required to pay the following deductible each calendar year for select services:

- \$200 for one member
- \$400 for a family (when two or more members are covered under your contract)
  - Two or more members must meet the family deductible
  - If the one member deductible has been met, but not the family deductible, we will pay covered services only for that member
  - Covered services for the remaining family members will be paid when the full family deductible has been met
  - Only the following select services are applicable to the deductible requirements of the contract:
    - Office, Outpatient and Home Medical and Clinic Visits
    - Office and Outpatient Consultations
    - Post-natal care
    - Allergy Testing and Therapy
    - Ambulance Transportation (ground and air)
    - Chiropractic Spinal Manipulations/Osteopathic Manipulative Therapy
    - Durable Medical Equipment
    - Prosthetic and Orthotic Appliances
    - Private Duty Nursing

**We will not apply charges toward your deductible if one of the following applies:**

- The charges exceed our approved amount.
- The charges are for noncovered services.

Deductible requirements will not be imposed for certain care management services performed by select Michigan-based providers, as identified by BCBSM.

**Copayment and  
Coinsurance  
Requirements**

You are required to pay the following copayment and coinsurance:

- \$250 copayment per visit for non-emergency medical care
- 20 percent of the approved amount for select services
- 50 percent of the approved amount for private duty nursing

Only the following select services are applicable to the coinsurance requirements of the contract:

- Office, Outpatient and Home Medical and Clinic Visits
- Office and Outpatient Consultations
- Injections
- Post-natal care
- Allergy Testing and Therapy
- Ambulance Transportation (ground and air)
- Chiropractic Spinal Manipulations/Osteopathic Manipulative Therapy
- Durable Medical Equipment
- Medical Supplies
- Prosthetic and Orthotic Appliances
- Accidental Dental Services
- Private Duty Nursing

**Copayment and Coinsurance Requirements**  
(continued)

BCBSM will waive any copayment and coinsurance amounts required under your contract when a select Michigan-based provider, as identified by BCBSM, provides certain care management services to a BCBSM member.

**We will not apply charges toward your copayment or coinsurance that:**

- Exceed our approved amount
- Are for noncovered services or
- Apply to copayments and coinsurances paid under other certificates

**Annual Maximums**

**Annual Out-of-Pocket Maximum:**

Your annual out-of-pocket maximum is:

- \$1,200 for a one member contract
- \$1,400 for a family contract (when two or more members are covered under your contract)

Your **deductible, copayment and coinsurance** requirements for all covered services are combined to meet the annual out-of-pocket maximum. If you have prescription drug coverage, your cost-sharing requirements under your BCBSM prescription drug certificate also contribute to the annual out-of-pocket maximums stated above.

Once the annual out-of-pocket maximum is met, no more cost-sharing will be required for the remainder of the calendar year under this certificate.

**Maximums for Days of Care or Visits:**

If annual maximums (days or visits) or lifetime maximums (days or visits) apply for specific services, they are described elsewhere in your certificate.

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## **Section 3: Coverage for Hospital, Facility and Alternatives to Hospital Care**

**The services listed in this section are covered when services are provided in accordance with certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.**

**This section describes the hospital, facility and alternatives to hospital care covered under this certificate. It includes:**

- **HOSPITAL AND FACILITY CARE**

- Inpatient Hospital Services That Are Payable
- Inpatient Hospital Services That Are Not Payable
- Hospital Admissions That Are Not Payable
- Outpatient Hospital Services That Are Payable
- Outpatient Hospital Services That Are Not Payable
- Outpatient Mental Health Facility Services
- Freestanding Ambulatory Surgery Facility Services
- Freestanding Outpatient Physical Therapy Facility Services
- Freestanding ESRD Facility Services
- Long-Term Acute Care Hospital Services

- **ALTERNATIVES TO HOSPITAL CARE**

- Home Health Care Services
- Infusion Therapy
- Hospice Care Services
- Alternative Facility Services That Are Not Payable

- **HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

- Participating Providers
- Nonparticipating Providers
- Emergency Services at a Nonparticipating Hospital
- Services That You Must Pay
- Out-of-Area Services
- BlueCard® Program
- Negotiated (non-BlueCard Program) National Account Arrangements
- BlueCard Worldwide® Program

## **HOSPITAL AND FACILITY CARE**

The services described in this section must be:

- Prescribed by the attending physician, and
- Provided during an inpatient hospital stay or
- Provided in the outpatient department of a hospital or facility

This section has information about benefits provided in or by a **participating** hospital or facility. It includes:

- Inpatient Hospital Services
- Outpatient Hospital and Facility Services
- Outpatient Mental Health Facility Services
- Freestanding Ambulatory Surgery Facility Services
- Freestanding Outpatient Physical Therapy Facility Services
- Home Health Care Services
- Infusion Therapy
- Hospice Care Services

For information about benefits provided in a nonparticipating hospital or facility, see Page 3.51.

Medical services provided in accordance with the terms of this certificate are covered services only when they are medically necessary (see the definition of “medically necessary” in Section 7), including BCBSM-approved non-contractual services that may be described in your treatment plan for case management.

**NOTE:** Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

## **HOSPITAL AND FACILITY CARE**

### **Inpatient Hospital Services That Are Payable**

- Semiprivate room
- Nursing services
- Meals, including special diets
- Operating room services, including delivery and surgical treatment rooms
- Services provided in a special care unit, such as intensive care
- Anesthetics given by a qualified employee of the hospital
- Diagnostic laboratory and pathology tests/services that are provided under the direction of a pathologist employed by the hospital
- Oxygen and other therapeutic gases and their administration
- Covered services and devices for pain management when medically necessary as documented by a physician
- Psychological tests directly related to the condition for which the patient is admitted or when such tests have a full role in rehabilitative or psychiatric treatment programs
- Medical supplies such as gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Cardiac rehabilitation services begun during an admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)

## HOSPITAL AND FACILITY CARE

### Inpatient Hospital Services That Are Payable (continued)

- Physical therapy treatment, speech and language pathology services, and occupational therapy used to treat the condition for which the member is hospitalized

#### **Physical therapy** must be:

- Prescribed by a physician licensed to prescribe it, and
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given by:
  - An M.D., D.O. or podiatrist
  - A licensed physical therapist under the direction of a physician
  - A physical therapist assistant under the general supervision of a licensed physical therapist, M.D. or D.O.
  - Other individuals under the direct supervision of a licensed physical therapist, M.D. or D.O.

#### Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Physical therapy** must be: (continued)

Services do not include: (continued)

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

**Speech and language pathology services** must be:

- Prescribed by a physician licensed to prescribe them, and
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

**NOTE:** The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Services do not include:

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

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Speech and language pathology services** must be:  
(continued)

Services do not include: (continued)

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

**NOTE:** For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

**Occupational therapy** must be:

- Prescribed by a physician licensed to prescribe it, and
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of Michigan)

**NOTE:** The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Occupational therapy** must be: (continued)

Services do not include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Sterilization, when medically necessary
- Prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) that are:
  - Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act and
  - Used during your stay in the hospital
- Special medical foods and formulas for metabolic diseases (see Section 4)
- Maternity care and routine newborn nursery care during a mother's eligible hospital stay

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

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

## HOSPITAL AND FACILITY CARE

### **Inpatient Hospital Services That Are Payable** (continued)

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Also, we may not set the level of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain preapproval. For information on preapproval, contact your BCBSM customer service representative (see Section 8).

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
- Drugs that are FDA-approved for use in chemotherapy treatment. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the Preauthorization for Specialty Pharmaceuticals requirement described on Page 4.27.

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

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

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

- Inhalation therapy
- Electroshock therapy
- Pulmonary function evaluation
- Radioactive isotope studies and use of radium owned or rented by the hospital
- Prosthetic devices permanently implanted in the body or those used externally as part of regular hospital equipment while you are in the hospital (for additional prosthetic and other orthotic benefits, see Page 5.7)
- External prosthetic and orthotic devices prescribed by a physician for use outside of the hospital
- Cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services
- Hyperbaric oxygenation (therapy given in a pressure chamber)
- Computerized axial tomography, magnetic resonance imaging and positron emission tomography scans provided in participating facilities
- Durable medical equipment:
  - Used in the hospital
  - Rented or purchased from the hospital at the time of discharge
- Cosmetic surgery for:
  - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

- Conditions caused by accidental injuries, and
- Traumatic scars

**NOTE:** Cosmetic surgery and related services are not payable when the services are primarily performed to improve appearance.

- Dialysis services, supplies and equipment to treat:
  - Acute renal (kidney) failure
  - End stage renal disease (ESRD)

ESRD treatment may also be provided in a participating freestanding facility or in the home (when provided through a program participating with BCBSM to provide such services).

**NOTE:** Dialysis services used primarily to treat ESRD are also covered by Medicare (individuals with ESRD should apply to Medicare). (See Pages 1.3 - 1.7 for details about ESRD.)

- Psychiatric day treatment or psychiatric night treatment in a participating hospital. We pay for:
  - Services provided by facility staff
  - Ancillary services to patients who are admitted and discharged on the same day of treatment
  - Prescribed drugs given by the hospital in connection with the treatment plan
  - Electroshock therapy when administered by, or under the supervision of, a physician
  - Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

– Psychological testing

– Family counseling

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

– A semiprivate room

– Nursing services

– Meals, including special diets

- Services performed to obtain, test, store and transplant only the following human tissues and organs:

– Kidney

– Cornea

– Skin

– Bone marrow (described below)

Immunization 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 (ACIP).

**NOTE:** The immunization benefit does **not** apply to cornea and skin transplants.

We will pay covered services for a donor if the donor does not have transplant benefits under any health care plan.

- Bone Marrow Transplants

Services must be rendered in a facility participating with BCBSM.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition, we pay for the following services:

### **Allogeneic Transplants**

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
  - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
  - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.)

**NOTE:** Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a BCBSM member. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Allogeneic Transplants** (continued)

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

**Autologous Transplants**

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

**NOTE:** A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of “Tandem Transplant” in Section 7.

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable  
(continued)**

**Allogeneic transplants are covered to treat the following conditions:**

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia
- Aplastic anemia (acquired or congenital, e.g., Fanconi's anemia or Diamond-Black fan syndrome)
- Beta Thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable  
(continued)**

**Allogeneic transplants are covered to treat the following conditions:** (continued)

- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- Renal cell CA
- Plasmacytomas

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Autologous transplants are covered to treat the following conditions:**

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

**NOTE:** In addition to the conditions listed above, we will pay for services related to, or for high-dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**We do not pay the following for bone marrow transplants:**

- Services that are not medically necessary (see Section 7 for the definition of medically necessary)
- Services rendered in a facility that does not participate with BCBSM
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Services rendered to a donor when the transplant recipient is not a BCBSM member
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- Expenses related to travel, meals and lodging for donor or recipient
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- Search of an international donor registry
- An allogeneic tandem transplant
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable  
(continued)**

**We do not pay the following for bone marrow transplants:** (continued)

- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

- **Oncology Clinical Trials**

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 are covered when they are provided pursuant to an approved phase II or III clinical trial. Benefits are not limited or precluded for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

**We will not pay benefits under this section for services, admissions or lengths of stay that are not preapproved.**

The preapproval process allows you and your provider to know if we will cover proposed services, hospital admissions and lengths of stay in a hospital before treatment begins. If preapproval 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:** Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur.

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

A decision to preapprove services, an admission or length of stay will be based on the information your provider submits to us. BCBSM reserves the right to request other information to determine if preapproval is appropriate.

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

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

Blue Cross Blue Shield of Michigan  
Human Organ Transplant Program  
Mail Code J607  
600 Lafayette East  
Detroit, MI 48226

Fax: (313) 225-5827

Preapproval will be granted if:

- The patient is an eligible BCBSM member.
- The patient has BCBSM hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient admission to a designated cancer 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 preapproved by BCBSM before the admission occurs.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Services That Are Payable**

The services covered in your basic certificate(s) and rider(s) are payable when directly related to a transplant covered under this section. The transplant must be performed at a designated cancer center or its affiliate to be a covered benefit.

Immunization 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 (ACIP).

We pay for the following only *after* they have been preapproved by BCBSM:

**Autologous Transplants**

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

**Allogeneic Transplants**

- Blood tests to evaluate donors (if not covered by the potential donor's insurance)

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Allogeneic Transplants** (continued)

- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood. (We will cover harvesting and storage even if it is not covered by the donor's insurance.)

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

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

**Travel and Lodging**

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

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Travel and Lodging** (continued)

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

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

**NOTE:** These daily allowances may be adjusted periodically. Please contact BCBSM for the current maximums allowed.

**Limitations and Exclusions**

In addition to the limitations and exclusions listed in your certificate(s) and rider(s), we do not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see Section 7 for the definition of “medically necessary”)
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor’s health care coverage will pay for such services

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Limitations and Exclusions** (continued)

- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this section
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or day care services, services provided by family members, reimbursement of food stamps; mail/UPS services; internet connection, and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or length of stay related to any of the above exclusions

The copayments and deductibles in your certificate apply to the services covered above, unless stated otherwise.

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

- Specified Human Organ Transplants
- When performed in a designated facility, we pay for transplantation of the following organs:
- Combined small intestine-liver
  - Heart
  - Heart-lung(s)
  - Liver
  - Lobar lung
  - Lung(s)
  - Pancreas
  - Partial liver
  - Kidney-liver
  - Simultaneous pancreas-kidney
  - Small intestine (small bowel)
  - Multivisceral transplants (as determined by BCBSM)

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.

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

Specified Human Organ Transplants (continued)

When directly related to the transplant, we pay for:

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

**NOTE:** We will pay for any service needed to treat a condition as a direct result of the organ transplant surgery if it is a benefit under any of our certificates.

We also pay for the following:

- Up to \$10,000 for eligible travel and lodging during the initial transplant surgery. This includes:

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

Specified Human Organ Transplants (continued)

- Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor)

**NOTE:** In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the \$10,000 maximum for travel and lodging.

- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient (“lodging” refers to a hotel or motel)
- Cost of acquiring the organ (the organ recipient must be a BCBSM member). This includes, but is not limited to:
  - Surgery to obtain the organ
  - Storage of the organ
  - Transportation of the organ
  - Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
- Payment for covered services for a donor if the donor does not have transplant services under any health care plan

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

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

Specified Human Organ Transplants (continued)

Limitations and Exclusions

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

We do not pay the following for specified human organ transplants:

- Services that are not BCBSM benefits
- Services rendered to a recipient who is not a BCBSM member
- Living donor transplants not listed in this certificate other than partial liver, lobar lung, and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Anti-rejection drugs that do not have Food and Drug Administration approval
- Transplant surgery and related services performed in a nondesignated facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility unless medically necessary and approved by the BCBSM medical director.
- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers,

## HOSPITAL AND FACILITY CARE

**Inpatient  
Hospital  
Services That  
Are Payable**  
(continued)

Specified Human Organ Transplants (continued)

Limitations and Exclusions (continued)

greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, Internet service, and entertainment (such as cable television, books, magazines and movie rentals))

- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate
- Experimental transplant procedures. See the "General Conditions of Your Contract" section for guidelines related to experimental treatment.

- **Voluntary Sterilizations for Males and Females**

We pay for voluntary sterilizations for males and females. Covered services are subject to the following cost-sharing requirements:

- Voluntary sterilizations for males and females performed in a **participating** hospital or facility are not subject to any cost-sharing requirements under your certificate or any riders you may have.
- Services performed in a **nonparticipating** hospital or facility are not covered.

## **HOSPITAL AND FACILITY CARE**

### **Inpatient Hospital Services That Are Not Payable**

In addition to the services described as nonpayable throughout the previous subsection, we also do not pay for the following:

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see Section 4 for payable physician services)
- Custodial care or rest therapy
- Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
- Human organ transplants, except those specifically listed on Pages 3.11 and 3.24 of this certificate
- Dental services except as follows:
  - Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting.

**NOTE:** In these cases we pay for facility and anesthesia services **only**, not for the services of a dentist or other dental professional.

Examples of such medical conditions are:

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

Procedures include:

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

**HOSPITAL AND FACILITY CARE**

**Inpatient  
Hospital  
Services That  
Are Not Payable**  
(continued)

- Dental services except as follows (continued)
  - Medical records must verify the patient’s concurrent hazardous medical condition.
  - We pay for dental care to treat accidental injuries or when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition.
- Services covered under any other Blue Cross or Blue Shield contract or under any health care benefits plan
- Screening services
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Non-contractual services described in your case management treatment plan when such services have not been approved by BCBSM

**Hospital  
Admissions  
That Are Not  
Payable**

Hospital admissions that are not covered by your certificate include:

- Those for care that is not considered acute, such as:
  - Observation
  - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
  - Diagnostic evaluations
  - Lab exams
  - Electrocardiography
  - Weight reduction
  - X-rays, exams or therapy
  - Cobalt or ultrasound studies
  - Basal metabolism tests
  - Convalescence or rest care
  - Convenience
- Those mainly for physical therapy, speech and language pathology services or occupational therapy

**HOSPITAL AND FACILITY CARE**

**Outpatient  
Hospital  
Services That  
Are Payable**

The services listed under "Inpatient Hospital Services That Are Payable" are also payable when provided as outpatient care (except for those related to inpatient room, board and inhalation therapy). However, the following requirements must also be met when services are provided on an outpatient basis:

- Emergency room services are payable when provided for the examination and treatment of medical emergencies or accidental injuries.
- Services to treat chronic conditions are payable when they require repeated visits to the hospital.
- Covered services and devices for pain management when medically necessary as documented by a physician
- Drugs, biologicals and solutions administered in a hospital are payable when they are part of the treatment of the disease, condition or injury.
- Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:
  - The treatment must be arranged by the patient's attending physician and the physician director or a committee of staff physicians of a self-dialysis training program.
  - The owner of the patient's home must give the hospital prior written permission to install the equipment.

**HOSPITAL AND FACILITY CARE**

**Outpatient  
Hospital  
Services That  
Are Payable**  
(continued)

We pay for:

- Placement and maintenance of a dialysis machine in the patient's home
- Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
- Laboratory tests related to the dialysis
- Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
- Removal of the equipment after it is no longer needed

The following dialysis services are not payable:

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

Physical therapy, speech and language pathology services and occupational therapy are payable when provided for rehabilitation.

## HOSPITAL AND FACILITY CARE

**Outpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Physical therapy** must be:

- Prescribed by an M.D., D.O., podiatrist or dentist
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
  - An M.D., D.O. or podiatrist
  - A physical therapist
  - A physical therapist assistant under the general supervision of a physical therapist
  - An athletic trainer under the direct supervision of a physical therapist

Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

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

## HOSPITAL AND FACILITY CARE

### Outpatient Hospital Services That Are Payable (continued)

**Speech and language pathology services** must be:

- Prescribed by an M.D., D.O. or dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
  - An M.D. or D.O.
  - A speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

**NOTE:** We do not pay for services provided by speech-language pathology assistants or therapy aides.

Services do not include:

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

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

**NOTE:** For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

## HOSPITAL AND FACILITY CARE

**Outpatient  
Hospital  
Services That  
Are Payable**  
(continued)

**Occupational therapy** must be:

- Prescribed by an M.D., D.O., podiatrist or dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
  - An M.D. or D.O.
  - An occupational therapist
  - An occupational therapy assistant under the direct supervision of an occupational therapist
  - An athletic trainer under the direct supervision of an occupational therapist

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

Services do not include:

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

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy

## HOSPITAL AND FACILITY CARE

### **Outpatient Hospital Services That Are Payable** (continued)

- Cardiac rehabilitation services are payable when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required.
- Two visits in a designated psychiatric day or night treatment center are allowed for each unused day of inpatient medical care (provided your coverage includes a specific number of days for inpatient medical care).
- Outpatient substance abuse services for the treatment of tobacco dependence are payable

### **Outpatient Hospital Services That Are Not Payable**

The services listed under “Inpatient Hospital Services That Are Not Payable” are also not payable when provided as outpatient care. In addition, we do not pay for:

- Outpatient inhalation therapy
- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable.

### **Outpatient Mental Health Facility Services**

Services in an outpatient mental health facility are payable only when the facility that provides and bills for them is a **participating** facility.

#### **Services That Are Payable**

- Mental health services provided by a physician, fully-licensed psychologist, clinical licensed master’s social worker or other professional provider as determined by BCBSM (see “Section 4: Coverage for Physician and Other Professional Provider Services”)

**HOSPITAL AND FACILITY CARE**

**Outpatient  
Mental Health  
Facility  
Services**  
(continued)

**Services That Are Payable** (continued)

- Services provided by the facility's staff
- Family counseling for members of the patient's family
- Ancillary services for patients who are admitted and discharged on the same day of treatment
- Prescribed drugs given by the facility in connection with treatment
- Psychological testing by a physician, a fully licensed psychologist, or a limited-licensed psychologist when prescribed and billed by a physician or fully licensed psychologist

**Services That Are Not Payable**

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided in a skilled nursing facility
- Marital counseling

## **HOSPITAL AND FACILITY CARE**

### **Freestanding Ambulatory Surgery Facility Services**

We pay for medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility. A patient must be under the care of a licensed M.D., D.O., podiatrist or oral surgeon to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by BCBSM as covered ambulatory surgery.

### **Services That Are Payable**

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

## HOSPITAL AND FACILITY CARE

### **Freestanding Ambulatory Surgery Facility Services**      **Services That Are Not Payable**

(continued)

We do not pay for:

- Services by a **nonparticipating** ambulatory surgery facility
- Professional services by a physician. These services, such as surgery, may be covered under Section 4.

### **Freestanding Outpatient Physical Therapy Facility Services**

We pay our approved amount for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility.

**NOTE:** We will pay the facility directly for the service and not the individual provider who rendered the service.

### **Services That Are Payable**

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for rehabilitation.

### **Services That Are Not Payable**

- Services of a freestanding facility provided to you while you are an inpatient in a hospital or skilled nursing facility
- Services provided to you in the home

### **Freestanding ESRD Facility Services**

We pay for medically necessary facility services provided by a BCBSM **participating** end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney failure.

## HOSPITAL AND FACILITY CARE

### Freestanding ESRD Facility Services (continued)

#### Services That Are Payable

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment
- Home dialysis (for conditions, benefits and exclusions that also apply to freestanding ESRD facility services, see dialysis services described in “Outpatient Hospital Services That Are Payable” on Pages 3.31 and 3.32)
  - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
  - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines

#### Services That Are Not Payable

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

## **HOSPITAL AND FACILITY CARE**

### **Long-Term Acute Care Hospital Services**

The services listed under “Inpatient Hospital Services That Are Payable” and “Outpatient Hospital Services That Are Payable” may also be payable when provided in a long-term acute care hospital, or LTACH.

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

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

Long-term acute care hospital services count toward any benefit maximums that apply to inpatient hospital services.

We do not pay for:

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

## **ALTERNATIVES TO HOSPITAL CARE**

### **Home Health Care Services**

**This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home.**

The services described below must be:

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

## **ALTERNATIVES TO HOSPITAL CARE**

### **Home Health Care Services** (continued)

The following criteria must be met:

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

### **Services That Are Payable**

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

- Skilled nursing care provided by or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, speech and language pathology services and occupational therapy, as described on Pages 3.4 – 3.7, are payable when provided for rehabilitation. If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered under the Home Health Care Program.

**ALTERNATIVES TO HOSPITAL CARE**

**Home Health  
Care Services**  
(continued)

**Services That Are Payable** (continued)

- Part-time health aide services, including preparing meals, laundering, bathing and feeding, if:
  - The patient is receiving skilled nursing care or physical or speech therapy
  - The patient's family cannot provide the services and the home health care agency has identified a need for these services for the patient to participate in the program
  - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

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

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

**Services That Are Not Payable**

- General housekeeping services
- Transportation to and from a hospital or other facility
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
- Physician services
- Custodial care or nonskilled care
- Services performed by a nonparticipating home health care provider

## ALTERNATIVES TO HOSPITAL CARE

### Infusion Therapy

**This program provides coverage for infusion therapy services in a participating ambulatory infusion center, or by a home infusion therapy provider whether or not you are confined to the home. Benefits will not be payable for services obtained in a nonparticipating ambulatory infusion center.**

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

Services include:

- Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy, please see the Preauthorization for Specialty Pharmaceuticals requirement described on Page 4.19.
- Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care

**NOTE:** Nursing services must meet BCBSM's medical necessity guidelines to be payable.

- Durable medical equipment, medical supplies and solutions needed for home infusion therapy

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

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

## ALTERNATIVES TO HOSPITAL CARE

### Hospice Care Services

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

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

For the first 90 days of hospice care coverage:

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

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

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

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

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

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

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

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

## **ALTERNATIVES TO HOSPITAL CARE**

### **Hospice Care Services** (continued)

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

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

- Medical director of the hospice **or**
- Physician of the hospice interdisciplinary group
- The patient or his or her representative must sign a “Waiver of Benefits” form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient’s (or family’s) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

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

### **Services That Are Payable**

Before electing to use hospice care services, the patient and his or her family are eligible to receive counseling, evaluation, education and support services from the hospice staff. These services are limited to a 28-visit maximum.

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

#### Home Care Services

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

**ALTERNATIVES TO HOSPITAL CARE**

**Hospice Care Services**

(continued)

Facility Services

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

Hospice Services

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

## **ALTERNATIVES TO HOSPITAL CARE**

### **Hospice Care Services**

(continued)

#### Hospice Services (continued)

The above services are limited to a maximum amount that is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under the case management program. Please call us for information about the current maximum amount.

#### Professional Services

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

**NOTE:** Payable services do not include physician services provided by a member of the hospice interdisciplinary team.

Payment for professional services is limited to a maximum amount, determined by BCBSM, which is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under the case management program. Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services.

**NOTE:** Hospice services are not subject to any deductible or copayments.

### **How to Cancel or Reinstate Hospice Care Services**

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

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

**ALTERNATIVES TO HOSPITAL CARE**

**Hospice Care Services**

(continued)

**Services That Are Not Payable**

We do not pay for services:

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

**Alternative Facility Services That Are Not Payable**

We do not pay for any services you receive in a skilled nursing facility, convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

**NOTE:** If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**Participating Providers**

Almost all Michigan hospitals and many alternatives to hospital care providers participate with BCBSM. Sometimes providers outside of Michigan participate with us. The provider sends the claims to us. We will pay our approved amount directly to the provider.

## HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

### **Participating Providers** (continued)

- The provider accepts our payment as payment in full, less any copayments or deductibles you are required to pay.
  - You do not need to pay any amount beyond copayments and deductibles that apply to medically necessary services covered by your certificate (except in the limited cases described below).
  - Even if the provider's charge for a covered service is more than our payment, you will not need to pay the difference.

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

### **Nonparticipating Providers**

**If you go to a nonparticipating hospital, facility or alternative to hospital care provider, you will need to pay most of the charges yourself.** Your bill could be substantial. To receive payment for covered services (less any copayments or deductibles you are required to pay) you will need to send us a claim.

(Call your customer service representative for information on filing claims. See Section 8.)

**BCBSM does not pay for services at nonparticipating outpatient physical therapy facilities, freestanding ambulatory surgery facilities, mental health or substance abuse treatment facilities, skilled nursing facilities, hospice programs, home health care agencies or by nonparticipating infusion therapy providers.**

BCBSM coverage at nonparticipating hospitals, both in and out of Michigan, is limited to services needed to treat an accidental injury or medical emergency. We do not pay for nonemergency services in a nonparticipating hospital. The following explains your coverage when provided by a nonparticipating hospital.

## HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

### Emergency Services at a Nonparticipating Hospital

We will pay our approved amount, less any member cost-sharing amounts, for emergency services provided by an **accredited nonparticipating hospital**:

- Located outside of Michigan in an area not served by another Blue Cross and/or Blue Shield Plan
- Located in Michigan but not participating with another Blue Cross and/or Blue Shield Plan
- Participating with another Blue Cross and/or Blue Shield Plan, regardless of the facility's location

### Services That You Must Pay

You are required to pay for the following services:

- Services that are not included in this certificate
- Services that are not covered because they are medically unnecessary or experimental **if** you agree to receive them after being advised by hospital staff that they will not be covered **and** you agree in advance and in writing to pay for them

In some cases, you **are required** to pay for services that **are medically necessary**. These limited cases are:

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

### Out-of-Area Services

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-Plan Programs.” When you obtain services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**Out-of-Area Services**  
(continued)

Typically, when receiving care outside our service area, you will obtain care from providers that have a contract (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield plan (“Host Plan”). In some instances, you may obtain care from nonparticipating providers. Our payment practices in both instances are described below.

**BlueCard® Program**

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard Program. This Program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard providers outside the area their local plan services. When you receive covered services in the area served by a Host Plan, we will pay for covered services. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating providers.

**BlueCard Participating Providers**

If you receive covered services in another service area from a BlueCard participating provider:

- The provider will file your claim with the Host Plan.
- The Host Plan will pay the provider the amount required under its contract with the provider less any deductible or copayment required under your BCBSM certificate.
- After the Host Plan pays the provider, BCBSM reimburses the Host Plan the amount required under the BlueCard Program.

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

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

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**BlueCard Program**  
(continued)

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If any state laws mandate other liability calculation methods, including a surcharge, we will calculate your liability for any covered services according to applicable law.

**Nonparticipating Providers Outside Our Service Area**

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

- Submit an itemized statement to us for the services. Call your customer service representative (see Section 8) for information on filing claims.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider. (We do not pay for services of nonparticipating facility providers listed on Page 3.50 and provide very limited coverage for services of nonparticipating hospitals.)

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**BlueCard Program**  
(continued)

To find out if an out of area provider is a BlueCard or BCBSM participating provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder website at [bcbs.com](http://bcbs.com) for a listing of participating providers.

**Subscriber Liability Calculation**

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services as set forth in this paragraph.

**Exceptions**

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the services had been obtained within our service area, or a special negotiated payment, as permitted under inter-plan programs policies, to determine the amount we will pay for services rendered by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

**Specialty Providers in the BlueCard Program**

The Host Plan can pay provider specialties recognized within the Host Plan's area (even if BCBSM does not contract with the particular provider specialty). If the Host Plan contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider's services can be paid.

## HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

### **BlueCard Program** (continued)

#### **BlueCard Program Exceptions**

The BlueCard Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services

### **Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

### **BlueCard Worldwide® Program**

The BlueCard Worldwide Program assists BCBSM members traveling or living outside of the United States in obtaining medical care services; provides access to a worldwide network of health care providers; and includes claims support services.

**NOTE:** In this BlueCard Worldwide Program Section, when we refer to participating or nonparticipating hospitals or physicians, we mean participating or nonparticipating in the BlueCard Worldwide Program.

#### **Medical Assistance Services**

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 1-800-810-BLUE (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

**Coverage for BlueCard Worldwide Participating Hospitals**

**Inpatient Hospital Services**

- Subscribers are responsible for calling the BlueCard Worldwide Service Center to arrange cashless access with a participating hospital if an inpatient admission is necessary. Cashless access means that the subscriber is only required to pay applicable deductible(s) and copayment(s) at the time of the admission for all covered services. The hospital will file the claim for the subscriber.
- Subscribers are responsible for deductible(s) and copayment(s).
- Subscribers are responsible for the payment of non-covered services.
- Subscribers are responsible for contacting BCBSM for preauthorization. Call the customer service number listed on the back of your BCBSM ID card.

**Outpatient Hospital Services**

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

**Coverage for Nonparticipating Hospitals**

**Inpatient Hospital Services**

- If subscribers are admitted to a nonparticipating hospital, they are responsible for calling the BlueCard Worldwide Service Center to try to arrange a referral for cashless access and approval from BCBSM. Cashless access means that the subscriber is only required to pay applicable deductible(s) and copayment(s) at the time of the admission for all covered services. If approved, the claim will be considered a participating provider payable claim. The hospital will file the claim for the subscriber.
- If cashless access is arranged, the subscriber will be responsible for the deductible(s) and copayment(s) and non-covered services.
- A subscriber who does not contact the Service Center to arrange cashless access and approval from BCBSM may be responsible for paying the entire admission.

**Outpatient Hospital Services**

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**Emergency Services at Participating or Nonparticipating Hospitals**

- In the case of an emergency, subscribers are advised to go to the nearest hospital.
- If hospitalized, subscribers are advised to follow the process for inpatient hospital services.

**HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

**Emergency Services at Participating or Nonparticipating Hospitals** (continued)

- If subscribers are not hospitalized, they are responsible for payment of all professional and outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**BlueCard Worldwide Professional Services**

- Subscribers are responsible for payment of all professional services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

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## **Section 4: Coverage for Physician and Other Professional Provider Services**

**The services listed in this section are covered when services are provided in accordance with certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.**

**This section describes physician and other professional provider services covered by your certificate. It tells you:**

- **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**
- **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**
- **HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**
  - Participating Providers
  - Nonparticipating Providers
  - Out-of-Area Services
  - BlueCard® Program
  - Negotiated (non-BlueCard Program) National Account Arrangements
  - BlueCard Worldwide® Program

**Medical services provided in accordance with the terms of this certificate are covered services only when they are medically necessary (see the definition of “medically necessary” in Section 7), including BCBSM-approved non-contractual services that may be described in your treatment plan for case management.**

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**In order to be paid, services must be provided by persons who are legally qualified or licensed to provide them.**

**We pay our approved amount for the services described in this section (deductible and copayment information is in Section 2). These pages explain the extent to which the service is covered.**

- Surgery
- Presurgical Consultation
- Anesthetics
- Technical Surgical Assistance
- Obstetrics
- Newborn Examination
- Inpatient Medical Care
- Inpatient Mental Health Care
- Outpatient Mental Health Care
- Inpatient Consultations
- Emergency Treatment
- Chemotherapy
- End Stage Renal Disease (ESRD)
- Therapeutic Radiology
- Diagnostic Radiology
- Diagnostic Services
- Diagnostic Laboratory and Pathology Services
- Allergy Testing and Therapy
- Chiropractic Services
- Physical, Speech and Language Pathology and Occupational Therapy Services
- Office, Outpatient and Home Medical Care Visits
- Cardiac Rehabilitation
- Optometrist Services
- Audiologist Services
- Specialty Pharmaceuticals
- Certified Nurse Midwife Services
- Certified Nurse Practitioner Services
- Injectable Drugs
- Pain Management
- Special Foods for Metabolic Diseases

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Surgery**

Payment includes:

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the patient is in the hospital
- Visits to the attending physician for the usual care before and after surgery

**Multiple Surgeries**

Multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by BCBSM.

**Restrictions**

- Dental surgery is payable **only** for:
  - Multiple extractions or removal of unerupted teeth or alveoplasty when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition (see Page 3.29 for examples)
  - Surgery on the temporomandibular joint (jaw joint) and related anesthesia services
  - Arthrocentesis performed for treatment of temporomandibular joint (jaw joint) dysfunction

**NOTE:** Temporomandibular joint (jaw joint) dysfunction diagnosis and/or treatment is payable only for the previous two items, surgery and arthrocentesis, and:

- Diagnostic X-rays
- Physical therapy (see Pages 4.21 - 4.25 for physical therapy services.)
- Reversible appliance therapy (mandibular orthotic repositioning)

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Surgery**  
(continued)

- Surgery for gender reassignment is payable **only** for reconstructive procedures of the genitalia. Surgical procedures involving the face, vocal cords, breasts, abdomen, hips or other nongenital areas are not payable.
- Cosmetic surgery is payable **only** for:
  - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
  - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
  - Conditions caused by accidental injuries
  - Traumatic scars

**NOTE:** Physician services for cosmetic surgery are **not payable** when services are primarily performed to improve appearance.

**Presurgical Consultation**

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon**.

You may obtain presurgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under this certificate.

You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion - a consultation to confirm the need for surgery
- Third opinion - allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion - given to determine your medical tolerance for the proposed surgery

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Presurgical Consultation**  
(continued)

Deductibles and copayments required under this certificate do not apply to presurgical consultations obtained from participating physicians.

**Anesthetics**

For surgery

Services for giving anesthetics to patients undergoing covered surgery are payable to either:

- A physician other than the operating physician
- A physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist in an:
  - Inpatient hospital setting
  - Outpatient hospital setting
  - Participating ambulatory surgery facility

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

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

**NOTE:** Anesthesiology services performed by a qualified employee of a hospital or facility are not covered in this section of the certificate. (See “Inpatient Hospital Services That Are Payable.”)

For infusion therapy

We pay for local anesthetics only when needed as part of infusion therapy done in the physician’s office.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Technical Surgical Assistance**

In some cases, an additional physician provides technical assistance to the surgeon. We pay the approved amount for TSA, provided according to BCBSM guidelines, in a hospital inpatient or outpatient setting or in an ambulatory surgery facility. A list of covered TSA surgeries is available from your local customer service center.

We do not pay for TSA:

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

**Obstetrics**

Prenatal and postnatal services are payable, as are services provided by the physician attending the delivery.

**Newborn Examination**

A newborn's routine care is payable when provided during the mother's inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the mother's attending physician.

**NOTE:** The baby must be eligible for coverage and must be added to your contract within 30 days of the birth. Ask your employer or call BCBSM.

**Inpatient Medical Care**

We pay for medical care by your attending physician while you are receiving inpatient services.

**Inpatient Mental Health Care**

We pay for the following inpatient mental health services when provided by a physician or a fully licensed psychologist with hospital privileges.

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

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Inpatient  
Mental Health  
Care**  
(continued)

- Psychological testing
- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition

**NOTE:** The assistance is required because of the special skill or knowledge of the consulting psychologist.

This certificate allows direct reimbursement to participating, fully licensed psychologists for the covered services described above. When a participating fully licensed psychologist submits a claim for covered services, we pay the provider *directly*.

For services provided by a nonparticipating, fully licensed psychologist, you should expect to pay the provider and then submit a claim to us. If we approve the claim, we will send payment to you minus the difference between our approved amount and the charge of the nonparticipating provider.

We pay for the following inpatient mental health service only when provided by a physician:

- Electroshock therapy and its related anesthetics

We do not pay for:

- Staff consultations required by a facility or program's rules
- Marital counseling
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Outpatient  
Mental Health  
Care**

Unless otherwise specified, we pay for the outpatient mental health services listed below when provided by a physician, fully licensed psychologist, clinical licensed master's social worker or other professional provider as determined by BCBSM in an office setting or in a participating outpatient mental health facility. (See "Outpatient Mental Health Facility Services" in Section 3 for a description of when these services are payable.)

- Individual psychotherapeutic treatment of less than 20 minutes provided in a participating outpatient mental health facility
- Individual psychotherapeutic treatment of more than 20 minutes
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing by:
  - A physician or a fully licensed psychologist or
  - A limited-licensed psychologist when prescribed and performed under, and billed by, a physician or fully licensed psychologist

We do not pay for:

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided to an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program. (Please see Page 3.10 for payable psychiatric day and night treatment.)
- Marital counseling

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Inpatient Consultations**

Inpatient consultations are payable when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill or knowledge of the consulting physician or professional provider.

**NOTE:** Outpatient and office consultations are payable as office visits.

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

**Emergency Treatment**

Services of one or more physicians for the exam and treatment of a medical emergency or an accidental injury are payable.

**Chemotherapy**

We pay our approved amount for chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the Preauthorization for Specialty Pharmaceuticals requirement described on Page 4.27.

To be payable the drugs must be:

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

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

- Current medical literature must confirm that the drug is effective for the disease being treated.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Chemotherapy**  
(continued)

- Recognized oncology organizations must generally accept the drug as treatment for the specific disease.
- The physician must obtain informed consent from the patient for the treatment.

We also pay for:

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

**NOTE:** Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on Pages 5.3 to 5.4.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**End Stage Renal Disease (ESRD)** Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a participating freestanding ESRD facility or in the home.

**NOTE:** Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. (Please see Pages 1.3 - 1.7 for a detailed explanation of your coverage if you have ESRD.)

**Therapeutic Radiology** We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by the attending physician or by another physician, if prescribed by the attending physician.

**Diagnostic Radiology** We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-rays
- Ultrasound
- Radioactive isotopes
- Computerized axial tomography (CAT) scans
- Magnetic resonance imaging (MRI) for specific diagnoses
- Positron emission tomography (PET) scans

**NOTE:** You may call us for information about any restrictions.

The services must be provided by your physician or by another physician if prescribed by your physician.

**NOTE:** Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Diagnostic Radiology**  
(continued)

We do not pay for procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

**Diagnostic Services**

We pay for diagnostic services used by a physician to diagnose disease, illness, pregnancy or injury.

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

We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

**Diagnostic Laboratory and Pathology Services**

We pay for laboratory and pathology services needed to diagnose a disease, illness, pregnancy or injury. The services must be provided by your physician or by another physician if prescribed by your physician.

- Standard office laboratory tests are payable when performed in a physician's office in connection with the medical care given at the time of the visit.

- NOTE:** Standard laboratory tests are tests that:
- BCBSM has identified as payable and
  - Are essential to the patient's care at the time of the visit (also referred to as "immediate results" tests)

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Diagnostic Laboratory and Pathology Services**  
(continued)

- Non-standard laboratory tests (tests that BCBSM has identified as payable and are not essential to the patient's care at the time of the visit) are payable only when prescribed by a physician and performed by a independent laboratory or outpatient hospital laboratory

**Allergy Testing and Therapy**

We pay for the following allergy testing and therapy services, performed by, or under the supervision of, a physician:

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

We do not pay for:

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

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Chiropractic and Osteopathic Manipulative Therapy Services**

We pay for the following chiropractic treatment:

- Chiropractic spinal manipulation to treat misaligned or displaced vertebrae of the spine and osteopathic manipulative therapy services are limited to a combined maximum of 38 visits per member, per calendar year. Services provided by participating and nonparticipating osteopaths and chiropractors are combined to meet the annual maximum.
- Chiropractic office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received services within 36 months.
  - For established patients, we pay for one office visit per year. An established patient is one who has received services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment

**Autism Disorders**

Covered 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.

Covered Services

**Diagnostic services** must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule.

**NOTE:** Before applied behavior analysis services will be covered, a MSU approved Autism Center of Excellence, must evaluate and diagnose the member as having one of the covered autism spectrum disorders.

**Autism  
Disorders**  
(continued)

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

- **Applied behavior analysis treatment.** It must be provided or supervised by a board certified behavior analyst or licensed psychologists so long as the services performed are commensurate with the psychologist's formal university 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 treatment** is covered subject to the following requirements:
  - **Treatment Plan** – Applied behavior analysis treatment must be included in a treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition. If requested by BCBSM, the cost of treatment review will be paid by BCBSM.
  - **Prior Authorization** – Applied behavior analysis treatment must be approved for payment through BCBSM's prior authorization process. If prior authorization is not obtained, rendered services will not be covered and the member will be responsible to pay for those services. Prior authorization is not required for any other covered autism services.
  - **Behavioral health treatment.** It includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.
  - **Psychiatric care.** It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

**Autism Disorders**  
(continued)

- **Psychological care.** It 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 your certificate or related riders.

- **Therapeutic care.** It 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 and appropriate
- Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder.
- Deemed safe and effective by BCBSM.

**NOTE:** Services or treatments that are deemed experimental or investigational by BCBSM, such as applied behavior analysis treatment, are covered only when they are approved by BCBSM and included in a treatment plan recommended by the BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition.

**Autism  
Disorders**  
(continued)

**Limitations and Exclusions**

In addition to those listed in this certificate and any riders that you may have, the following limitations and exclusions apply:

- Benefits for applied behavior analysis treatment are limited to children through the age of 19. This age limitation does not apply to psychiatric, psychological, non-applied behavior analysis services and services to diagnose autism.
- Payment for services to treat autism will not count toward any dollar maximums in your coverage including, but not limited to, dollar maximums on psychiatric and psychological services.
- Occupational therapy, physical therapy and speech and language pathology services for treatment of autism are subject to the visit limitations that apply to these services (if your certificate has visit limitations).
- All autism benefits including, but not limited to, medical-surgical services and/or behavioral health treatment covered under this certificate are subject to any hospital/medical deductibles and coinsurance imposed under this certificate.
- Any treatment that is not a covered benefit by BCBSM, 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 certificate.
- 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 certificate such as the exclusion of:
  - Experimental treatment
  - Treatment of chronic, developmental or congenital conditions

**Autism Disorders**  
(continued)

- 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 performed in Michigan must be provided by providers that are registered with BCBSM as a participating or nonparticipating provider.
  
  - All autism services performed outside of Michigan must be provided by providers that participate with its local Blue Cross/Blue Shield plan.

**Autism Diagnostic Observation Schedule**

The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the Michigan Department of Insurance and Financial Services, if this department determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

**Autism Center**

An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
  
- Recommend an initial high-level treatment plan for member's with autism spectrum disorders.

Please contact human resources to determine approved Autism Center of Excellence.

**Autism Disorders**  
(continued)

**Autism Spectrum Disorders**

Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

**Behavioral Health Treatment**

Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

**Board Certified Behavior Analyst**

An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

**NOTE:** Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

**Evaluation**

An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

**Line Therapy**

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

**Autism  
Disorders**  
(continued)

**Prior Authorization Process**

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

**Professional Provider**

One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Clinical licensed master's social worker
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by BCBSM

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

**Treatment Plan**

A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

**Autism Disorders**  
(continued)

Treatment Plan for Autism Disorders

A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

**Physical, Speech and Language Pathology and Occupational Therapy Services**

We pay for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.

**Physical therapy** must be:

- Prescribed by an M.D., D.O., podiatrist or dentist
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Physical,  
Speech and  
Language  
Pathology and  
Occupational  
Therapy  
Services**  
(continued)

We pay for physical therapy performed by:

- An M.D., D.O. or podiatrist
- A dentist for the oral-facial complex
- An optometrist for services for which he or she is licensed
- A chiropractor doing mechanical traction (see Chiropractic Services on Page 4.14)
- A physical therapist in a physician's or independent physical therapist's office
- An independent physical therapist in his or her office
- A physician assistant or certified nurse practitioner employed by a physician
- A certified nurse practitioner in an independent practice
- A physical therapist assistant under the general supervision of a physical therapist, M.D. or D.O.
- A physical therapist assistant under the general supervision of an independent physical therapist in the therapist's office
- An athletic trainer under the direct supervision of a physical therapist
- An athletic trainer under the direct supervision of an independent physical therapist in the therapist's office

Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Physical,  
Speech and  
Language  
Pathology and  
Occupational  
Therapy  
Services**  
(continued)

Services do not include: (continued)

- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

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

**Speech and language pathology services** must be:

- Prescribed by an M.D., D.O. or dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given by a speech-language pathologist (or an independent speech-language pathologist, in his or her office, who must be) certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

**NOTE:** We do not pay for services provided by speech-language pathology assistants or therapy aides.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Physical,  
Speech and  
Language  
Pathology and  
Occupational  
Therapy  
Services**  
(continued)

Services do not include:

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

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

**NOTE:** For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

**Occupational therapy** must be:

- Prescribed by an M.D., D.O., podiatrist or dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
  - An occupational therapist or an independent occupational therapist in his or her office
  - An occupational therapy assistant under the direct supervision of an occupational therapist

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Physical,  
Speech and  
Language  
Pathology and  
Occupational  
Therapy  
Services**  
(continued)

Given by: (continued)

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

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

Services do not include:

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

**NOTE:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy

**Office,  
Outpatient and  
Home Medical  
Care Visits**

We pay for office visits (including office consultations), outpatient and home medical care visits and therapeutic injections by a physician. The services must be to examine, diagnose and treat any condition of disease, pregnancy (including prenatal and postnatal care) or injury.

**NOTE:** You are not required to pay a copayment for presurgical consultations.

We do not pay for:

- Well-baby care
- Immunizations
- Routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Cardiac Rehabilitation**

We pay for intensive monitoring (EKGs) and/or supervision during exercise in a physician-directed clinic (one in which a physician is on-site).

**Optometrist Services**

We pay our approved amount for covered services performed by a licensed optometrist within the scope of his or her license.

- The medical and surgical services performed by the optometrist must be provided within the state of Michigan.
- The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.
- Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under BCBSM's vision program.

**Audiologist Services**

We pay our approved amount for covered services performed by an audiologist who is licensed or legally qualified to perform the services.

**NOTE:** To be payable, services performed by an audiologist must be referred by a provider who is legally authorized to prescribe the services.

**Specialty Pharmaceuticals**

We pay for BCBSM-approved specialty pharmaceuticals administered by a participating professional provider (see definition in "The Language of Health Care").

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

**NOTE:** Self-injected drugs are not covered.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Specialty  
Pharmaceuticals**  
(continued)

**Hemophilia Medication**

We pay for hemophilia factor product obtained from a panel, nonpanel, participating or nonparticipating professional provider (see definitions in “The Language of Health Care”).

The cost of the hemophilia factor product includes the supplies necessary for infusion. We will reimburse a participating provider directly; if the provider is nonparticipating, we will reimburse the member.

**Preauthorization for Specialty Pharmaceuticals**

Preauthorization is required for select specialty pharmaceuticals administered in locations as determined by BCBSM, including, but not limited to, the following: office, clinic or home. The preauthorization requirement affects all in-state and out-of-state services. The prescribing physician should contact BCBSM and follow BCBSM’s utilization management processes in order to obtain preauthorization of the specialty pharmaceuticals. Only FDA-approved medications can be preauthorized, and of those drugs, only the specialty pharmaceuticals that meet BCBSM’s medical policy criteria for treatment of the member’s condition will be preauthorized.

- If preauthorization is requested, but is not approved by BCBSM, you have the right to appeal under applicable law. If the preauthorization is not approved via the appeal, you will be responsible for the full cost of the specialty pharmaceuticals.
- If preauthorization is not sought, BCBSM will deny the claim and you will be responsible for the full cost of the specialty pharmaceuticals.
- Retrospective reviews will be available. If preauthorization is not sought and you appeal the denial, BCBSM will review the claim retrospectively to determine if benefits are payable. If BCBSM upholds

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Specialty Pharmaceuticals** (continued) the denial, you have the right to appeal under applicable law.

**NOTE: Preauthorization is not required if Medicare is your primary payer.**

**Certified Nurse Midwife Services** We pay for covered services provided by a certified nurse midwife. These covered certified nurse midwife services include, but are not limited to:

- Normal vaginal delivery when provided in:
  - An inpatient hospital setting
  - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
- Prenatal care
- Postnatal care, including a Papanicolaou (PAP) smear during the six-week visit

**Certified Nurse Practitioner Services** We pay for covered services provided by a certified nurse practitioner.

**Injectable Drugs** We pay for covered injectable drugs or biologicals and their administration. The injectable drugs and biologicals must be FDA approved in order to be covered. The injectable drug or biological must be ordered or furnished by a physician and administered by the physician or under the physician's supervision.

**Pain Management** Covered services and devices for pain management when medically necessary as documented by a physician

**Special Foods for Metabolic Diseases** We pay for special medical foods, including special infant formulas and low-protein modified food products, for the dietary treatment of inherited metabolic diseases of childhood, after a complete medical evaluation by the physician of the patient's condition. These foods will not be

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Special Foods  
for Metabolic  
Diseases**  
(continued)

covered unless they are prescribed by a physician after he or she has performed a complete medical evaluation.

The following criteria apply:

- The cost of special medical foods must be higher than the cost of foods that are not special medical foods.
- Medical documentation must support the diagnosis of a covered condition that requires special medical foods, as identified by BCBSM.
- A medical formula will be provided for infants from birth through 24 months when the formula represents at least 50 percent of the child’s caloric intake.
- Special medical foods and low-protein modified foods will be covered for pediatric patients up to and including age 18.

You must submit a prescription from the treating physician along with receipts for all special dietary purchases to BCBSM for handling. Mail your receipts along with a “Member Application for Payment Consideration” to:

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

You can obtain the above-mentioned form by visiting our website at **bcbsm.com** and clicking on “Member Forms” under the “Member Secured Services” tab. If you can’t access the website or you have trouble finding what you need, please contact Customer Service at one of the telephone numbers listed in Section 8.

All member cost-sharing requirements apply.

**We do not pay for the following:**

- Nutritional products, supplements, medical foods, infant formulas or low-protein modified foods for medical conditions not identified by BCBSM as being related to inherited metabolic diseases of childhood

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Special Foods for Metabolic Diseases**  
(continued)

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

- Foods used by patients with inherited diseases of childhood that are not special medical foods, special infant formulas or low-protein modified foods
- Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs
- Diabetes mellitus is excluded as a payable diagnosis for this benefit

**Contraceptive Devices**

We pay the approved amount for a contraceptive device requiring a prescription by a physician and for the insertion and removal of an intrauterine device by a licensed physician.

Contraceptive device benefits are not subject to any deductible, copayment or coinsurance requirements imposed under your certificate or any riders you may have when performed by a **participating** or **nonparticipating** provider.

**Contraceptive Injections**

We pay the approved amount for contraceptive injections. Our payment for the contraceptive injection also includes the cost of the medication when provided by the physician.

**NOTE:** Contraceptive medication you obtain from a pharmacy is not covered under this certificate. When the physician injects contraceptive medication you purchased from a pharmacy, only the injection is payable under this certificate.

Contraceptive injection benefits are not subject to any deductible, copayment or coinsurance requirements imposed under your certificate or any riders you may have when performed by a **participating** or **nonparticipating** provider.

**Voluntary Sterilizations for Males and Females**

We pay for voluntary sterilizations for males and females. Covered services are subject to the following cost-sharing requirements:

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**

**Voluntary Sterilizations for Males and Females**

(continued)

- Voluntary sterilizations for males and females performed by **participating** or **nonparticipating** providers are not subject to any cost-sharing requirements under your certificate or any riders you may have.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**

**The following services are not payable:**

- Medical supplies, most durable medical equipment and prescription drugs when it relates to diabetic care
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- Screening services, unless otherwise stated
- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on Page 4.4
- Health care services provided by persons who are not eligible for payment or appropriately credentialed or privileged (as determined by BCBSM) or providers who are not legally authorized or licensed to order or provide such services

**NOTE:** If BCBSM has not credentialed or privileged a participating/PPO panel provider to perform a service, the provider will be financially responsible for the entire cost of the service and cannot bill you for it. This includes the charge for the service and any copayments, deductibles or other cost-sharing amounts. If you receive services from a nonparticipating/nonpanel provider who is not credentialed or privileged to perform the service, you will have to pay for the entire cost of the service.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**

**The following services are not payable:** (continued)

- Dental care except to treat accidental injuries or multiple extractions or removal of unerupted teeth or alveoplasty when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition (see Page 3.29 for examples).
- Pre-employment, premarital, school and sports physicals unless needed to diagnose or treat a specific disease, illness, pregnancy or injury
- Weight loss programs
- Rest therapy or services provided to you while you are in a skilled nursing facility, convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

**NOTE:** If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

- Services, care, supplies or devices not prescribed by a physician
- Non-contractual services described in your case management treatment plan when such services have not been approved by BCBSM

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**

**The following services are not payable:** (continued)

- Services provided during nonemergency medical transport
- Immunizations
- Experimental treatment
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Hearing aids or services to examine, prepare, fit or obtain hearing aids
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Hospital services, including services provided by hospital employees (see Section 3)
- Drugs, medical appliances, materials or supplies (see Pages 3.7 - 3.8 for an explanation of when these services are covered)
- Any irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** for:
  - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
  - Diagnostic X-rays
  - Arthrocentesis
  - Physical therapy (see Page 4.21 for physical therapy services)

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**

**The following services are not payable:** (continued)

**NOTE:** The above restriction applies to any condition causing temporomandibular joint (jaw joint) dysfunction.

- Self-treatment by a professional provider and services given to parents, siblings, spouse or children
- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable
- Infertility services that do not treat a medical condition, other than infertility. This can include services such as:
  - Sperm washing
  - Post-coital test
  - Monitoring of ovarian response to ovulatory stimulants
  - In vitro fertilization
  - Ovarian wedge resection or ovarian drilling
  - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
  - Diagnostic studies done for the sole purpose of infertility assessment
  - Any procedure done to enhance reproductive capacity or fertility

**NOTE:** You or your physician can call us to determine if other proposed services are not covered benefits under your certificate.

## HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

**We pay the approved amount for each medically necessary covered service. Your copayment and/or deductible, if applicable, is subtracted from the approved amount before we make our payment.**

### **Participating Providers**

- The participating provider submits a claim to us for the services you receive.
- We pay the provider directly for the covered services.

A participating provider, other than an M.D., D.O., podiatrist, chiropractor, fully licensed psychologist or oral surgeon **may bill you** when:

- You receive a service not covered by your contract
- You acknowledge that we will not pay for medically unnecessary services and you agree, in writing, before receiving the services, that you will pay
- We deny a claim from a participating provider that was submitted more than 180 days after the service because you did not furnish needed information

Participating M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists, oral surgeons and other providers identified by BCBSM may bill you for services not covered by your certificate. However, if the service is not covered because BCBSM determined that it was not medically necessary or was experimental, the provider may bill you only if:

- You acknowledge in writing before you receive the service that we will not cover the service because it is medically unnecessary or experimental and you agree to receive the service and pay for it, and
- The provider gives you an estimate of what the services will cost you.

## HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

### **Participating Providers** (continued)

Participating providers may also bill you for a claim that is submitted to BCBSM after the time allowed because you failed to furnish the provider with required identifying information. In this situation, the provider may bill you only if a claim was submitted within three months after the provider obtained the necessary information.

Participating providers may **not** bill you for:

- Services that are not covered because BCBSM determined that the provider was ineligible or lacked the appropriate credentials or privileges needed to perform the service, or
- An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM.

### **Nonparticipating Providers**

You should expect to pay charges to a nonparticipating provider at the time you receive the services. You should then submit a claim to us. If we approve the claim, we will send our payment to the subscriber.

**NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

Nonparticipating providers, except independent physical therapists, certified nurse practitioners, independent occupational therapists, independent speech-language pathologists, and audiologists, **may** agree to participate on a per claim basis. This means that they will accept the approved amount as payment in full for a specific service. If so:

- The provider will submit a claim to us
- We will send our payment to the nonparticipating provider

### **Out-of-Area Services**

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**Out-of-Area Services**  
(continued)

Plan Programs.” When you obtain services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

Typically, when receiving care outside our service area, you will obtain care from providers that have a contract (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield plan (“Host Plan”). In some instances, you may obtain care from nonparticipating providers. Our payment practices in both instances are described below.

**BlueCard® Program**

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard Program. This Program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard providers outside the area their local plan services. When you receive covered services in the area served by a Host Plan, we will pay for covered services. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating providers.

**BlueCard Participating Providers**

If you receive covered services in another service area from a BlueCard participating provider:

- The provider will file your claim with the Host Plan.
- The Host Plan will pay the provider the amount required under its contract with the provider less any deductible or copayment required under your BCBSM certificate.
- After the Host Plan pays the provider, BCBSM reimburses the Host Plan the amount required under the BlueCard Program.

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

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**BlueCard  
Program**  
(continued)

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If any state laws mandate other liability calculation methods, including a surcharge, we will calculate your liability for any covered services according to applicable law.

**Nonparticipating Providers Outside Our Service Area**

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

- Submit an itemized statement to us for the services. Call your customer service representative (see Section 8) for information on filing claims.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider.

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**BlueCard  
Program**  
(continued)

To find out if an out of area provider is a BlueCard or BCBSM participating provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder website at [www.bcbs.com](http://www.bcbs.com) for a listing of participating providers.

**Subscriber Liability Calculation**

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services as set forth in this paragraph.

**Exceptions**

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the services had been obtained within our service area, or a special negotiated payment, as permitted under inter-plan programs policies, to determine the amount we will pay for services rendered by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

**Specialty Providers in the BlueCard Program**

The Host Plan can pay provider specialties recognized within the Host Plan's area (even if BCBSM does not contract with the particular provider specialty). If the Host Plan contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider's services can be paid.

## HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

### **BlueCard Program** (continued)

#### **BlueCard Program Exceptions**

The BlueCard Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services

### **Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

### **BlueCard Worldwide® Program**

The BlueCard Worldwide Program assists BCBSM members traveling or living outside of the United States in obtaining medical care services; provides access to a worldwide network of health care providers; and includes claims support services.

**NOTE:** In this BlueCard Worldwide Program Section, when we refer to participating or nonparticipating hospitals or physicians, we mean participating or nonparticipating in the BlueCard Worldwide Program.

#### **Medical Assistance Services**

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 1-800-810-BLUE (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

**Coverage for BlueCard Worldwide Participating  
Hospitals**

**Inpatient Hospital Services**

- Subscribers are responsible for calling the BlueCard Worldwide Service Center to arrange cashless access with a participating hospital if an inpatient admission is necessary. Cashless access means that the subscriber is only required to pay applicable deductible(s) and copayment(s) at the time of the admission for all covered services. The hospital will file the claim for the subscriber.
- Subscribers are responsible for deductible(s) and copayment(s).
- Subscribers are responsible for the payment of non-covered services.
- Subscribers are responsible for contacting BCBSM for preauthorization. Call the customer service number listed on the back of your BCBSM ID card.

**Outpatient Hospital Services**

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

**Coverage for Nonparticipating Hospitals**

**Inpatient Hospital Services**

- If subscribers are admitted to a nonparticipating hospital, they are responsible for calling the BlueCard Worldwide Service Center to try to arrange a referral for cashless access and approval from BCBSM. Cashless access means that the subscriber is only required to pay applicable deductible(s) and copayment(s) at the time of the admission for all covered services. If approved, the claim will be considered a participating provider payable claim. The hospital will file the claim for the subscriber.
- If cashless access is arranged, the subscriber will be responsible for the deductible(s) and copayment(s) and non-covered services.
- A subscriber who does not contact the Service Center to arrange cashless access and approval from BCBSM may be responsible for paying the entire admission.

**Outpatient Hospital Services**

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.

**Emergency Services at Participating or Nonparticipating Hospitals**

- In the case of an emergency, subscribers are advised to go to the nearest hospital.
- If hospitalized, subscribers are advised to follow the process for inpatient hospital services.
- If subscribers are not hospitalized, they are responsible for payment of all professional and outpatient services at the time the services are rendered.

**HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**

**BlueCard  
Worldwide  
Program**  
(continued)

- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

**BlueCard Worldwide Professional Services**

- Subscribers are responsible for payment of all professional services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at [bcbs.com/bluecardworldwide](http://bcbs.com/bluecardworldwide).
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

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## Section 5: Coverage for Other Health Care Services

**The services listed in this section are covered when services are provided in accordance with certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.**

**Medical services provided in accordance with the terms of this certificate are covered services only when they are medically necessary (see the definition of “medically necessary” in Section 7), including BCBSM-approved non-contractual services that may be described in your treatment plan for case management.**

**This section describes coverage for other health care services in addition to your hospital, facility and professional provider services. Unless otherwise noted, the facility and professional services listed below are paid as described in Section 3 and Section 4.**

**Dental Care and  
Dental  
Appliances**     Emergency Dental Treatment

We pay our approved amount for treatment of accidental injuries. An accidental injury is defined as occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

We pay for emergency treatment within 24 hours of the injury to relieve pain and discomfort.

You must complete follow-up treatment within six months of the injury.

**Dental Care and  
Dental  
Appliances**  
(continued)

We do not pay for:

- Treatment that was previously paid as a result of an accident
- Dental conditions existing before the accident
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Services to treat temporomandibular joint dysfunction (as described below)

Temporomandibular Joint (Jaw Joint) Dysfunction

We do not pay for medical and/or dental services performed for irreversible treatment of temporomandibular joint (jaw joint) dysfunction, except for:

- Surgery directly to the temporomandibular (jaw joint) and related anesthesia services
- Diagnostic X-rays
- Arthrocentesis
- Physical therapy (see Page 4.21 for physical therapy services)
- Reversible appliance therapy (mandibular orthotic repositioning)

**NOTE:** The above restriction applies to any condition causing temporomandibular joint (jaw joint) dysfunction.

**Durable Medical Equipment**

We pay our approved amount for rental or purchase of durable medical equipment when prescribed by a physician or certified nurse practitioner and obtained from a DME supplier who meets BCBSM qualification standards. In many instances we cover the same items covered by Medicare Part B as of the date of purchase or rental. In some instances however, BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

DME items must meet the following guidelines:

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

**NOTE:** If the equipment is:

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

Continuous Positive Airway Pressure (CPAP) Devices

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

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.

**Durable Medical  
Equipment**  
(continued)

Continuous Positive Airway Pressure (CPAP) Devices  
(continued)

We will pay for the purchase of any related supplies and accessories.

- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier must document your compliance.
- If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment.
- If you fail to comply with treatment requirements, we will also no longer cover the purchase of supplies and accessories.

We do not pay for:

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

**Medical Supplies**

We pay up to the approved amount for medically necessary quantities of medical supplies and dressings used in your home for the treatment of a specific medical condition. Refer to Section 7 for the definition of “medically necessary.”

**Private Duty Nursing Services**

We pay our approved amount for skilled care given by a private duty nurse in your home or in a hospital if:

- The patient’s medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient

We do not pay for custodial care.

**NOTE:** Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to us for the services. **All progress notes must be submitted with the claim.** We will pay the approved amount to you.

**Professional Ambulance Services**

We pay for ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient’s condition. In either case, the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient’s health.

**Professional Ambulance Services**

(continued)

- The service must be to transport the patient to a hospital or to transfer the patient between a hospital and another treatment location.

**NOTE:** When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation. (Services by fire departments, rescue squads or other emergency transport providers whose fees are in the form of a voluntary donation are not payable.)
- The fee must be only for the transportation of the patient, and not include additional services that may be provided by physicians or other professionals but billed as ambulance service.

**NOTE:** When air ambulance service is required, it is payable if:

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

We pay the approved amount for ambulance service when the ambulance has responded and the patient is stabilized and transport is not necessary or is refused and in instances where the ambulance company arrives but the person that needed treatment has expired.

**Prosthetic and  
Orthotic  
Devices**

We pay our approved amount for prosthetic and orthotic devices prescribed by a physician or certified nurse practitioner. This includes the cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features. Repairs, limited to the cost of a new device, are also covered. The prescription must include a description of the equipment and the reason for the need or the diagnosis.

**NOTE:** For purposes of ocular prostheses only, the definition of physician includes an optometrist who is also a prosthetist.

The replacement of a prosthetic device is payable if necessary due to:

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

**Coverage Guidelines**

BCBSM covers external prosthetic and orthotic devices that are generally considered payable by Medicare Part B as of the date of purchase or rental. In some instances however, BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

To be covered, custom-made devices must be furnished by a provider that is fully accredited or, with BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC). You can call us to confirm a provider's status.

Prosthetic and orthotic suppliers may include M.D.s, D.O.s, podiatrists, prosthetists and orthotists who meet BCBSM qualification standards.

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

**Prosthetic and  
Orthotic  
Devices**  
(continued)

**Coverage Guidelines** (continued)

- External breast prostheses following a mastectomy. These include:
  - Two post-surgical brassieres **and**
  - Two brassieres in any 12-month period thereafter

Additional brassieres are covered if they are required because of a significant change in body weight or for hygienic reasons

- Prefabricated custom-fitted orthotic devices
- Artificial eyes, ears, noses and larynxes
- Ostomy sets and accessories, catheterization equipment and urinary sets
- Prescription lenses (eyeglasses or contacts) following cataract surgery for any disease of the eye or to replace a missing organic lens. Optometrists may provide these devices.
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses (as defined in Section 7) when approved by BCBSM. Dentists may provide these devices.
- Some prefabricated items, such as wrist braces, ankle braces, or shoulder immobilizers, are payable when provided by an M.D., D.O., or podiatrist because the patient has an urgent need for the device. Please call your local customer service center for information on which devices are covered.

**Prosthetic and Orthotic Devices**  
(continued)

**Devices and Services That Are Not Payable**

Some prosthetic and orthotic devices and services are not covered under your certificate. These include:

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

**Outpatient Diabetes Management Program**

We pay up to the approved amount for selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O. Refer to Section 7 for the definition of “medically necessary.”

Diabetes services and medical supplies include:

- Insulin pumps
- Medical supplies required for the use of an insulin pump
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
- Diabetes self-management training conducted in a group setting, whenever practicable, if:
  - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge

**Outpatient  
Diabetes  
Management  
Program  
(continued)**

- Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment

The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

**NOTE:** Coverage for syringes, insulin and prescription drug benefits is provided if you do not have coverage under a prescription drug carrier.

**Preventive Care  
Services**

We pay for the immunizations and preventive care services listed below and for additional benefits that are mandated under the Patient Protection and Affordable Care Act (PPACA) at the time the services are performed.

**NOTE:** To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to the following website: <https://www.healthcare.gov/coverage/preventive-care-benefits/>. You may also contact BCBSM customer service.

**Preventive Care  
Services  
(continued)**

We will pay 100 percent of our approved amount, not subject to any deductible or copayment requirements, for services obtained from a participating or nonparticipating provider. However, if a nonparticipating provider charges more than BCBSM's approved amount, you are responsible for paying the difference.

- **Health Maintenance Examination**  
One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.
- **Flexible Sigmoidoscopy Examination**  
One routine flexible sigmoidoscopy examination per member, per calendar year.

- **Gynecological Examination**  
One routine gynecological examination per member, per calendar year.
- **Routine Pap Smear**  
Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.
- **Fecal Occult Blood Screening**  
One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.
- **Prostate Specific Antigen Screening**  
We pay for one routine prostate specific antigen screening per member, per calendar year.
- **Routine Laboratory and Radiology Services**  
We pay for the following services once per member, per calendar year, when performed as routine screening:
  - Chemical profile
  - Complete blood count or any of its components
  - Urinalysis
  - Chest X-ray
  - EKG
  - Cholesterol testing
- **Well-Baby and Child Care Visits**  
We pay for well-baby and child care visits as follows:
  - Six visits for children from birth through 12 months
  - Six visits for children 13 months through 23 months
  - Six visits for children 24 months through 35 months
  - Two visits for children 36 months through 47 months
  - Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit
- **Immunizations**  
We pay for childhood and adult immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM.

**Preventive Care Services (continued)**

- **Screening Mammography**

Screening mammography services are payable at 100 percent of the BCBSM approved amount of your certificate as follows:

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

- **Colonoscopy**

Benefits for colonoscopy services are payable at 100 percent of the BCBSM approved amount as follows:

We pay for one routine screening colonoscopy once per member per calendar year.

- Routine screening colonoscopies are limited to once per member per calendar year. Medically necessary colonoscopies are not limited to once per member per calendar year.

**Temporary Benefits for Hospital Services**

**Mandatory Preapproval**

Preapproval of the services described in this section (except emergency care or ambulance services) must be obtained from BCBSM before we will consider them for payment. If the required approval is not obtained, you must pay for these services.

Our customer service representatives can provide you and your physician with the telephone number to call for preapproval (see the “How to Reach Us” section of this certificate). If the request for preapproval relates to a bone marrow or organ transplant, please ask your customer service representative for the telephone number of the Human Organ Transplant Program.

**NOTE:** Preapproval of services is not a guarantee that a claim for them will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claim is processed as well as the requirements, conditions, limitations, exclusions, maximums, deductibles and copayments under your certificate.

**Temporary  
Benefits for  
Hospital  
Services  
(continued)**

**Preapproval must be obtained as follows:**

- **Designated Services**

- Your physician must obtain preapproval for designated services by calling BCBSM. If preapproval is not obtained, the designated services you receive will not be covered and you will be responsible for the hospital's charges.

- **Travel and Lodging**

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

**Payable Services**

- Designated Services and Emergency Care

Coverage Requirements

We will pay for designated services and emergency care (as defined above) that you receive from a non-contracted area hospital when all of the following criteria are met:

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

**Temporary  
Benefits for  
Hospital  
Services**

(continued)

Payment for Designated Services and Emergency Care

When the above criteria are met, we will pay the subscriber as follows:

- Designated Services
  - We will pay our approved amount, less any deductibles and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.
- Emergency Care
  - We will pay our approved amount rather than the rate for emergency care specified in your certificate. You are responsible for any deductibles and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.

Transport from a Non-contracted Area Hospital

If you are receiving designated services or emergency care and your physician determines you are medically stable, you may choose to be transferred from the non-contracted area hospital to the nearest participating hospital equipped to treat your condition. We will pay our approved amount for your one-way ambulance transport to that hospital.

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

Your certificate provides only limited coverage for emergency services at nonparticipating hospitals and no coverage for nonemergency admissions. If you choose to remain in the non-contracted area hospital, payment for your continued stay will be limited to the amount we pay nonparticipating hospitals, as described in your certificate.

**Temporary  
Benefits for  
Hospital  
Services**

(continued)

Limitations and Exclusions

- If you go to a non-contracted area hospital and receive services that we determine are not designated services, our payment will be limited to the amount we pay nonparticipating hospitals, as described in your certificate. The balance you owe may be substantial since we do not pay for nonemergency services in a nonparticipating hospital.
- We will not pay for designated services that were not preapproved, as described above.
- Ambulance transport services are payable under this certificate only if related to an admission covered under this certificate. However, if your certificate covers nonemergency transports, you will be responsible for any deductibles or copayments required under your certificate.
- 

**Travel and Lodging**

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

- You live within 75 miles of the non-contracted area hospital
- You cannot reasonably obtain covered services from a contracted area hospital or other participating provider within 75 miles of the non-contracted area hospital and your physician directs you to an out-of-area hospital, and
- You obtain services from the out-of-area BCBSM participating hospital that is closest to the non-contracted area hospital.

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

Inpatient Services

If you require inpatient services from an out-of-area hospital, we will pay up to \$250 per day for the reasonable and necessary cost of travel and lodging up to a maximum of \$5,000 per admission. These maximums apply to the combined expenses for you and the person(s) eligible to accompany you. Our payment will be the lesser of your actual expenses or the \$250 or \$5,000 maximums.

**Temporary  
Benefits for  
Hospital  
Services**

(continued)

Coverage will begin on the day before your admission and end on your date of discharge. We will pay for the following:

- Travel for you and another person (two persons if the patient is a child under the age of 18) to and from the out-of-area hospital
- Lodging for the person(s) eligible to accompany you

**Temporary  
Benefits for  
Hospital  
Services**  
(continued)

Outpatient Services

If you require outpatient services from an out-of-area hospital or from a physician, we will pay up to \$125 for travel and lodging each time you require these services. Physician services must be directly related to an admission to an out-of-area hospital.

Limitations and Exclusions

- We do not pay for travel and lodging that were not preapproved, as described above.
- Travel and lodging will be paid only after you submit your original receipts to us.
- Travel does not include an ambulance transport to an out-of-area hospital.
- We do not pay for travel and lodging beyond the maximums stated above.
- We will not pay for items that we do not consider directly related to travel and lodging, such as: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, household utilities (including cellular telephones), maids, babysitters or daycare services and entertainment such as cable television, books, magazines, movie rentals or charges for hospital services that are not covered (telephone, television, private room).
- Deductibles or copayments required under your certificate will not apply to travel and lodging.

**When Benefits End**

The benefits covered under this section are temporary. They will end six months from the date a non-contracted hospital terminated its participating contract with BCBSM.

**Clinical Trials  
(Routine  
Patient Costs)**

For oncology clinical trial services, see Section 3.

We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual, as defined in this certificate.

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

Benefits are subject to the conditions described below.

**We pay for:**

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

**NOTE:** See definitions of approved clinical trial, life-threatening condition, routine patient costs, and qualified individual in Section 7.

**We do not pay for:**

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

**Clinical Trials  
(Routine  
Patient Costs)**  
(continued)

**NOTE: If one or more BCBSM-contracted (participating or in-network) providers participate in an approved clinical trial, BCBSM may require members to participate in the trial through one of those providers unless the trial is conducted outside of Michigan.**

**Substance  
Abuse  
Treatment**

We pay for medical care by a physician for treatment of substance abuse in residential and outpatient substance abuse treatment programs.

We pay for the assistance of a consulting physician when you are in an approved residential substance abuse treatment program if the physician in charge of your case requests the assistance because special skill or knowledge is required to diagnose or treat the condition.

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

We pay for residential and outpatient substance abuse treatment program services if the following criteria for the program are met:

- Your physician must assign a diagnosis of substance abuse. The physician must certify whether the treatment required is residential or outpatient.
- Your physician must:
  - Provide an initial exam
  - Provide and supervise your care during detoxification
  - Provide follow-up care during rehabilitation
- The services must be medically necessary for the treatment of your condition
- The services must be approved by BCBSM and provided by an approved substance abuse treatment program
- You must have program benefits available

**Substance Abuse Treatment**  
(continued)

**Services That Are Payable**

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

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

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

- Bed and board, including general nursing services
- Drugs, biologicals and solutions used in the facility

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

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

**Services Not Payable**

- Services provided primarily for a diagnosis other than substance abuse
- Dispensing methadone or testing urine specimens, unless you are receiving therapy, counseling or psychological testing

**Substance Abuse Treatment**  
(continued)

**Services Not Payable** (continued)

- Diversional therapy
- Services provided beyond the period necessary for care and treatment
- Services provided during the portion of any residential admission that occurs before the effective date of this certificate
  - Benefits are payable for the balance of an admission when coverage under this certificate terminates during the admission.

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## Section 6: General Conditions of Your Contract

**This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.**

### **Assignment**

The services provided under this certificate are for your personal benefit and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all your rights under it. No right to payment from us, claim or cause of action against us may be assigned by you to any provider. We will not pay any provider except under the terms of this contract.

### **Care and Services That Are Not Payable**

We do not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate
- Those available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government-sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Any services not listed in this certificate as being payable

### **Changes in Your Family**

We must be notified by your employer or group within 30 days of any changes in your family. This requires you to complete an enrollment/change of status form with your employer or group. Any coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service. An enrollment/change of status form should be completed when you have a change of address.

## Section 6: General Conditions of Your Contract

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

- Any changes must be in writing and approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits by issuing a rider. Keep any riders you receive with this certificate.

**Coordination of Benefits** We coordinate the benefits payable under this certificate pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this certificate are also covered and payable under another group health care plan, we combine our payment with that of the other plan to pay the maximum amount we routinely pay for the covered services.

**Coverage for Drugs and Devices** We do not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

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

**NOTE:** Chemotherapeutic drugs are not subject to this general condition.

## Section 6: General Conditions of Your Contract

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### **Deductibles and Copayments Paid Under Other Certificates**

We do not pay deductibles or copayments that you were required to pay under any other certificate.

### **Experimental Treatment**

#### Services That Are Not Payable

We do not pay for experimental treatment (including experimental drugs or devices) or services related to experimental treatment, except as explained under “Clinical Trials (Routine Patient Costs)” in Section 5, “Oncology Clinical Trials” in Section 3 and “Services That Are Payable” below. In addition, we do not pay for administrative costs related to experimental treatment or for research management.

**NOTE:** This certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

#### How BCBSM Determines If a Treatment Is Experimental

If a treatment, including items and services, is not covered under “Clinical Trials (Routine Patient Costs)” in Section 5 or “Oncology Clinical Trials” in Section 3, BCBSM’s medical director will determine whether it is experimental. For example, a treatment, item or service may be determined to be experimental when:

- Medical literature or clinical experience is inconclusive as to whether the service is safe or effective for treatment of any condition, or
- It has been shown to be safe and effective treatment for some conditions, but there is inadequate medical literature or clinical experience to support its use in treating the patient’s condition, or
- Medical literature or clinical experience has shown the service to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same service, or

## Section 6: General Conditions of Your Contract

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### **Experimental Treatment** (continued)

- It is being studied in an on-going clinical trial, or
- There is a written informed consent used by the treating provider in which the service is referred to as experimental or investigational or other than conventional or standard treatment.

**NOTE:** The medical director may consider other factors.

When available, the following sources will be considered in evaluating whether a treatment is experimental under the above criteria:

- Scientific data, such as controlled studies in peer-reviewed journals or medical literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- Approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Assessment (OHTA) and other governmental agencies
- Accepted national standards of practice in the medical profession
- Approval by the Institutional Review Board of the hospital or medical center

**NOTE:** The medical director may consider other sources.

### Services That Are Payable

**We pay** for experimental treatment items and services related to the experimental treatment when **all** of the following are met:

## Section 6: General Conditions of Your Contract

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### **Experimental Treatment** (continued)

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The treatment is covered under your certificates when it is provided as conventional treatment.
- The services related to the experimental treatment are covered under your certificates when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM) or the related items or services are routine patient costs that are covered under “Clinical Trials (Routine Patient Costs)” in Section 5.

**NOTE:** This certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

### Limitations and Exclusions

- This section of your certificate does not provide coverage for services not otherwise covered under your certificates.
- Drugs or devices provided to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the member’s condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

### **Illness or Injuries Resulting from War**

Services are not payable for the treatment of illness or injuries resulting from declared or undeclared military acts of war.

## Section 6: General Conditions of Your Contract

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**Improper Use of Contract** If you allow any ineligible person to receive benefits (or try to receive benefits) under your contract, we may:

- Refuse to pay benefits
- Cancel your contract
- Begin legal action against you
- Refuse to cover your health care services at a later date

**Notification** When we need to notify you, we mail the notice to your employer or remitting agent or to your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.

**Other Coverage** In certain cases, we may have paid for health care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:

- You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. You grant us the lien or right of reimbursement regardless of 1) whether the money or other valuable consideration is designated as economic or non-economic damages, 2) whether the recovery is partial or complete, and 3) who holds the money or other valuable consideration or where it is held.
- You agree to inform us when you hire an attorney to represent you, and to inform your attorney of our rights under this certificate.
- You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining our written consent if we paid for the treatment you received for that injury.

## Section 6: General Conditions of Your Contract

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**Other Coverage** (continued) • You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.

- You acknowledge and agree that this certificate supercedes any made whole doctrine, collateral source rule, common fund doctrine or other equitable distribution principles.

**Payment of Covered Services** The covered services described in this certificate, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by BCBSM.

**Personal Costs** We will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

**Physician of Choice** You may continue to receive services from the physician of your choice.

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

**Release of Information** **You agree** to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

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

**Reliance on Verbal Communications** Verbal verification of a member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, and the availability of benefits at the time the claim is processed as well as to the conditions, limitations, exclusions, maximums, deductibles and copayments under your coverage.

## Section 6: General Conditions of Your Contract

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### **Right to Interpret Contract**

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law.

### **Semiprivate Room Availability**

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

### **Services Before Coverage Begins or After Coverage Ends**

Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at an acute care hospital, our payment will be based on the hospital's contract with us. Our payment may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**
- Only the services, treatment, care or supplies you receive while your coverage is in effect.

Our payment will cover only the services, treatment, care or supplies you receive while your coverage is in effect if your coverage begins or ends while you are:

- An inpatient in a facility such as: hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, **or**
- Under a course of treatment for an episode of illness from a home health agency, ESRD facility or outpatient hospital physical/occupational/speech therapy unit or other facility identified by BCBSM.

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**Section 6: General Conditions of Your Contract**

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<b>Services Before Coverage Begins or After Coverage Ends</b> (continued)	In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your BCBSM coverage or after it ends.
<b>Subscriber Liability</b>	At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.
<b>Time Limit for Legal Action</b>	Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.
<b>Unlicensed and Unauthorized Providers</b>	Benefits are not payable for health care services provided by persons who are not appropriately credentialed or privileged (as determined by BCBSM), or legally authorized or licensed to order or provide such services.
<b>What Laws Apply</b>	This certificate will be interpreted under the laws of the state of Michigan.
<b>Workers Compensation</b>	We do not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.

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## Section 7: 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 (ESRD) and to certain disabled persons.

### 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 ESRD and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a beneficiary.

You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are 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 monthly for the medical insurance portion. This premium is adjusted annually. You will be notified of the change before each new year.

### Employed Persons Aged 65 or Older

When you reach 65 and become eligible for Medicare, but are still working for an employer of 20 or more persons, you have two options for health care coverage. You may either:

- Continue your regular current coverage as your primary health care plan
- Select Medicare as your primary health care plan.
- The following explains these options:

#### Option 1

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

**Important:** If you continue to be covered by your group plan as your primary plan, you should still apply for Medicare benefits, especially Part A.

- Part A of Medicare, the hospital insurance, is offered without cost to you. It may provide **additional** benefits to your group coverage.

## **Section 8: The Language of Health Care**

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- Part B of Medicare, the medical insurance, 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 are no longer covered by your group plan and ends seven months later.

### **Option 2**

You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit your employer from providing you with Supplemental coverage.

**Note:** If you have a spouse who is 65 or older and is covered under your group plan, your employer must provide the same coverage you select to your spouse until you retire or leave employment.

### **Blue Cross Blue Shield Supplemental Coverage for Members on Medicare**

If you have Supplemental coverage, it works with your Medicare coverage to extend your health care benefits. Supplemental coverage works like this:

- **Medical Coverage**—Your group coverage, in combination with Medicare, provides the same benefits described throughout this handbook. Your Medicare deductibles and coinsurance are covered **if the service is a covered medical benefit. You are still responsible for any medical deductible and coinsurance/copayments required under the Supplemental coverage.**
- **Prescription Drug Coverage** — Your benefits remain as described in the “Prescription Drug Coverage” section.
- **Dental Care Coverage** — Your benefits remain as described in the “Dental Care Coverage” section.
- **Vision Care Coverage** — Your benefits remain as described in the “Vision Care Coverage” section.

### **Supplemental Coverage Exclusions and Limitations**

Your Blue Cross Blue Shield 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

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- Admissions or care received **before** the effective date of coverage or **after** the coverage termination date
- Drugs other than prescription drugs furnished during your stay in a hospital or skilled nursing facility
- Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care, and examinations for eyeglasses or hearing aids

## **Section 8: The Language of Health Care**

**This section explains the terms used in your certificate.**

### **Accidental Injury**

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

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as a bee sting or another insect bite
- Burns, frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

### **Accredited Hospital**

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

### **Acute Care**

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

### **Acute Care Facility**

A facility that offers a wide range of medical, surgical, obstetrical and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care

## **Section 8: The Language of Health Care**

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- Care of the aged or substance abusers
- Skilled nursing or other nursing care

### **Administrative Costs**

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

## Section 8: The Language of Health Care

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<b>Advanced Practice Psychiatric Nurse</b>	A person who has a master's degree or higher in nursing and a certification in Adult Psychiatric and Mental Health Nursing or Child & Adolescent psychiatric and Mental Health Nursing through the American Nurses Credentialing Center (ANCC).
<b>Affiliate Cancer Center</b>	A health care provider that has contracted with an NCI-approved cancer center to provide treatment.
<b>Allogeneic (Allogenic) Transplant</b>	A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord blood to transplant into the patient. This includes syngeneic transplants.
<b>Ambulatory Surgery</b>	Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a doctor's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.
<b>Ambulatory Surgery Facility</b>	A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.
<b>Ancillary Services</b>	Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.
<b>Approved Amount</b>	The lower of the billed charge or our maximum payment level for the covered service. Deductibles, copayments and/or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.
<b>Approved Clinical Trial</b>	<p>A Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:</p> <ul style="list-style-type: none"><li>• A federally-funded trial, as described in the Patient Protection and Affordable Care Act</li><li>• A trial conducted under an investigational new drug application reviewed by the Federal Food and Drug Administration</li></ul>

## **Section 8: The Language of Health Care**

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### **Approved Clinical Trial** (continued)

- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Care Act

### **Approved Substance Abuse Treatment Program**

A residential or outpatient program that provides medical or other services for substance abusers, meets all state licensure and BCBSM approval requirements, and has entered into an agreement with BCBSM to provide those services.

### **Arthrocentesis**

Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

### **Attending Physician**

The physician in charge of a case who exercises overall responsibility for the patient's care:

- Within a facility (such as a hospital or other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivered by other physicians and/or ancillary staff.

### **Audiologist**

A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

<b>Autologous Transplant</b>	A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.
<b>BCBSM</b>	Blue Cross Blue Shield of Michigan.
<b>Benefit Period</b>	The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.
<b>Biological</b>	A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.
<b>BlueCard® Participating Provider</b>	A provider who participates with the Host Plan.
<b>BlueCard® Program</b>	A program that allows Blue Cross Blue Shield members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.
<b>BlueCard Worldwide® Program</b>	A program that provides access to a network of inpatient facilities and medical assistance services worldwide, including referrals to professional providers for all Blue Cross Blue Shield of Michigan Members whose claims are eligible for processing through the BlueCard Program.

## Section 8: The Language of Health Care

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<b>Blue Cross Plan</b>	Any <u>hospital service plan</u> approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.
<b>Blue Shield Plan</b>	Any <u>medical service plan</u> approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.
<b>Carrier</b>	An insurance company that provides a health care plan for its members.
<b>Certificate</b>	This book, which describes your benefit plan, <b>and</b> any riders that amend this certificate.
<b>Certified Nurse Midwife</b>	A nurse who provides some maternity services and who: <ul style="list-style-type: none"><li>• Is licensed as a registered nurse by the state of Michigan</li><li>• Has a specialty certification as a nurse midwife by the Michigan Board of Nursing</li><li>• Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing</li></ul>
<b>Certified Nurse Practitioner</b>	A nurse who provides some medical services and who: <ul style="list-style-type: none"><li>• Is licensed as a registered nurse by the state of Michigan</li><li>• Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing</li><li>• Meets BCBSM qualification standards</li><li>• When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.</li></ul>

**Certified  
Registered Nurse  
Anesthetist**

A nurse who provides anesthesiology services and who:

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

**Chronic  
Condition**

A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of a chronic condition.

**Claim for  
Damages**

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

**Clinical  
Licensed  
Master's Social  
Worker**

A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

<b>Clinical Trial</b>	<p>A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:</p> <ul style="list-style-type: none"><li>• Phase II – a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.</li><li>• Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.</li></ul>
<b>Coinsurance</b>	<p>A percentage of the approved amount that you must pay for a covered service after your deductible, if required, has been met.</p>
<b>Colony Stimulating Growth Factors</b>	<p>Factors that stimulate the multiplication of very young blood cells.</p>
<b>Congenital Condition</b>	<p>A condition that is diagnosed at or after birth, such as severe articulation disorders and severe stuttering.</p>
<b>Contraceptive Device</b>	<p>A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.</p>

## **Section 8: The Language of Health Care**

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<b>Contraceptive Medication</b>	Any drug used for the express purpose of preventing pregnancy at the time of its administration.
<b>Contract</b>	This certificate and any related riders, your signed application for coverage and your BCBSM ID card.
<b>Contracted Area Hospital</b>	A BCBSM participating hospital located in the same area as a noncontracted area hospital.
<b>Conventional Treatment</b>	Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.
<b>Coordination Period</b>	A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.
<b>Copayment</b>	The flat-dollar portion of the approved amount that you must pay for a covered service after your deductible, if required, has been met.
<b>Covered Services</b>	A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.
<b>Custodial Care</b>	Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.
<b>Deductible</b>	The amount that you must pay for covered services, under any certificate, before benefits are payable.
<b>Dental Care</b>	Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

## Section 8: The Language of Health Care

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<b>Designated Cancer Center</b>	A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.
<b>Designated Facility</b>	To be a covered benefit, human organ transplants must take place in a “BCBSM-designated” facility. A <b>designated facility</b> is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.
<b>Designated Services</b>	Services that BCBSM determines only a noncontracted area hospital is equipped to provide.
<b>Developmental Condition</b>	A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.
<b>Dialysis</b>	The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.
<b>Direct Supervision</b>	The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.
<b>Dual Entitlement</b>	When an individual is entitled to Medicare on the basis of both ESRD and age or disability.
<b>Durable Medical Equipment</b>	Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.
<b>Effective Date</b>	The date your coverage begins under this contract. This date is established by BCBSM.
<b>Emergency Care</b>	Care to treat an accidental injury or medical emergency.

**Emergency Medical Condition**

Emergency Medical Condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

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

**Emergency Services**

Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

**End Stage Renal Disease (ESRD)**

Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal failure.

**Enrollment Date**

The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

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<b>Entitlement (or Entitled)</b>	The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.
<b>Exclusions</b>	Situations, conditions or services that are not covered by the subscriber's contract.
<b>Experimental Treatment</b>	Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."
<b>Facility</b>	A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.
<b>First Degree Relative</b>	An immediate family member; who is directly related to the patient: either a parent, sibling or a child.
<b>First Priority Security Interest</b>	<p>The right to be paid before any other person from any money or other valuable consideration recovered by:</p> <ul style="list-style-type: none"><li>• Judgment or settlement of a legal action</li><li>• Settlement not due to legal action</li><li>• Undisputed payment</li></ul> <p>This right may be invoked without regard for:</p> <ul style="list-style-type: none"><li>• Whether plaintiff's recovery is partial or complete</li><li>• Who holds the recovery</li><li>• Where the recovery is held</li></ul>

## Section 8: The Language of Health Care

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<b>Food and Drug Administration (FDA)</b>	An agency within the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.
<b>Freestanding Outpatient Physical Therapy Facility</b>	An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and occupational therapy or speech and language pathology services.
<b>Group</b>	A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.
<b>Hazardous Medical Condition</b>	The dangerous state of health of a patient who is at risk for loss, harm, injury or death.
<b>Hematopoietic Transplant</b>	A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.
<b>Hemodialysis</b>	The use of a machine to clean wastes from the blood after the kidneys have failed.
<b>High-Dose Chemotherapy</b>	A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.
<b>High-Risk Patient</b>	An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

**HLA Genetic Markers**

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

**Home Health Care Agency**

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

**Hospice**

A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

**Hospital**

A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis **and**
- Is fully licensed and certified as a hospital, as required by all applicable laws **and**
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

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

## Section 8: The Language of Health Care

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### **Hospital** (continued)

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

### **Hospital Privileges**

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

### **Host Plan**

A Blue Cross and/or Blue Shield Plan outside of Michigan that participates in the BlueCard Program and processes claims for services that you receive in that state.

### **Independent Occupational Therapist**

An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

### **Independent Physical Therapist**

A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Independent  
Speech-  
Language  
Pathologist**

A speech-language pathologist who provides some speech-language therapy services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

**Infusion  
Therapy**

The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

**Injectable Drugs**

Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

**Irreversible  
Treatment**

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

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- Treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
  - Crowns, inlays, caps, restorations, grinding
  - Orthodontics, such as braces, orthopedic repositioning and traction

**Irreversible Treatment**  
(continued)

- Installation of removable or fixed dental appliances such as dentures, partial dentures or bridges
- Surgery directly to the jaw joint and related anesthesia services
- Arthrocentesis

**Jaw Joint Disorders**

These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain, an inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly.

**Lien**

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff's injuries.

**Life-threatening Condition**

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

**Lobar Lung**

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

**Long-Term Acute Care Hospital**

A specialty hospital that focuses on treating patients requiring extended, intensive care; meets BCBSM qualification standards; and is certified by Medicare as an LTACH.

**Mandibular Orthotic Reposition Device**

An appliance used in the treatment of temporomandibular joint dysfunction.

## **Section 8: The Language of Health Care**

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<b>Maternity Care</b>	Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.
<b>Maxillofacial Prosthesis</b>	A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.
<b>Medical Emergency</b>	A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.
<b>Medical Evidence Report</b>	A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.
<b>Medically Necessary</b>	<p>A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.</p> <p><b>Medical necessity for payment of professional provider services:</b></p> <p>Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:</p> <ul style="list-style-type: none"><li>• In accordance with generally accepted standards of medical practice;</li><li>• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and</li><li>• Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.</li></ul>

**Medically  
Necessary**  
(continued)

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

**Medical necessity for payment of hospital and LTACH services:**

Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis
- **Appropriate** means that the type, level and length of care, treatment or supply and setting is needed to provide safe and adequate care and treatment.
  - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
  - The services are not mainly for the convenience of the member or health care provider.
  - The treatment is not generally regarded as experimental by BCBSM.
  - The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

**Medically  
Necessary**  
(continued)

**Medical necessity for payment of services of other  
providers:**

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

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

**Member**

Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

**Noncontracted  
Area Hospital**

A BCBSM nonparticipating hospital located in an area defined by BCBSM.

**Nonparticipating  
Hospital**

A hospital that has not signed a participation agreement with BCBSM to accept our approved amount as payment in full.

**Nonparticipating  
Providers**

Physicians and other health care professionals, hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

<b>Occupational Therapy</b>	<p>A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:</p> <ul style="list-style-type: none"><li>• Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery</li><li>• Help the patient learn to apply the newly restored or improved function to meet the demands of daily living, or</li><li>• Design and use splints, orthoses (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)</li></ul>
<b>Off-Label</b>	<p>The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.</p>
<b>Optometrist</b>	<p>A person licensed to practice optometry in the state the service is provided.</p>
<b>Orthopedic Shoes</b>	<p>Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.</p>
<b>Orthotic Device</b>	<p>An appliance worn outside the body to correct a body defect of form or function.</p>
<b>Out-of-Area Hospital</b>	<p>A BCBSM participating hospital that is more than 75 miles from a non-contracted area hospital. It is not in the same area as a contracted or non-contracted area hospital.</p>
<b>Out-of-Area Services</b>	<p>Services available to members living or traveling outside a health plan's service area.</p>
<b>Outpatient Mental Health Facility</b>	<p>A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.</p>

<b>Outpatient Substance Abuse Treatment Program</b>	A program that provides medical and other services on an outpatient basis specifically for drug or alcohol abusers.
<b>Partial Liver</b>	A portion of the liver taken from a cadaver or living donor.
<b>Participating Hospital</b>	A hospital that has signed a participation agreement with BCBSM to accept our approved amount as payment in full. Copayments or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.
<b>Participating Providers</b>	Physicians and other health care professionals, hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.
<b>Patient</b>	The subscriber or eligible dependent who is awaiting or receiving medical care and treatment.
<b>Per Claim Participation</b>	Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.
<b>Peripheral Blood Stem Cell Transplant</b>	A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.
<b>Peritoneal Dialysis</b>	Removal of toxic substances from the body by perfusion of a chemical solution through the abdomen.
<b>Pheresis</b>	Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).
<b>Physical Therapist</b>	A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

<b>Physical Therapy</b>	<p>The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:</p> <ul style="list-style-type: none"><li>• Muscle strength</li><li>• Joint motion</li><li>• Coordination</li><li>• General mobility</li></ul>
<b>Physician</b>	<p>A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners."</p>
<b>Plaintiff</b>	<p>The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.</p>
<b>Practitioner</b>	<p>A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master's social worker or oral surgeon) or other professional provider who participates with BCBSM or who is on a BCBSM PPO panel. Practitioner may also be referred to as "participating" or "panel" provider.</p>
<b>Preapproval</b>	<p>A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained <b>before</b> you receive certain services described in this certificate, they will not be covered.</p>
<b>Prescriber</b>	<p>A health care professional authorized by law to prescribe "Rx only" drugs for the treatment of human conditions.</p>
<b>Prescription</b>	<p>An order for medication or supplies written by a health care professional authorized by law to prescribe "Rx only" drugs for the treatment of human conditions.</p>

<b>Presurgical Consultation</b>	A consultation that allows a member to get an additional opinion from a physician who is a <b>doctor of medicine, osteopathy, podiatry or an oral surgeon</b> when surgery is recommended.
<b>Primary Payer</b>	The health care coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM group coverage and Medicare.)
<b>Primary Plan</b>	The health care plan obligated to pay for services before any other health care plan that covers the member or patient.
<b>Professional Provider</b>	<p>One of the following:</p> <ul style="list-style-type: none"><li>• Doctor of Medicine (M.D.)</li><li>• Doctor of Osteopathy (D.O.)</li><li>• Podiatrist</li><li>• Chiropractor</li><li>• Fully licensed psychologist</li><li>• Clinical licensed master’s social worker</li><li>• Oral surgeon</li><li>• Other providers as identified by BCBSM</li></ul> <p>Professional providers may also be referred to as “practitioners.”</p>

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<b>Prosthetic Device</b>	<p>An artificial appliance that:</p> <ul style="list-style-type: none"><li>• Replaces all or part of a body part or</li><li>• Replaces all or part of the functions of a permanently disabled or poorly functioning body organ</li></ul>
<b>Provider</b>	<p>A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.</p>
<b>Psychiatric Day Treatment</b>	<p>Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.</p>
<b>Psychiatric Night Treatment</b>	<p>Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.</p>
<b>Psychologist</b>	<p>A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.</p>
<b>Purging</b>	<p>A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.</p>
<b>Qualified Beneficiary</b>	<p>Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).</p>
<b>Qualified Individual</b>	<p>An individual eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:</p> <ul style="list-style-type: none"><li>• The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or</li><li>• The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols</li></ul>

<b>Qualifying Event</b>	<p>One of the following events that allows a qualified beneficiary to receive COBRA coverage:</p> <ul style="list-style-type: none"><li>• Termination of employment, other than for gross misconduct, or reduction of hours</li><li>• Death of the employee</li><li>• Divorce</li><li>• Loss of dependent status due to age, marriage, change in student status, etc.</li><li>• The employee becomes entitled to coverage under Medicare</li></ul>
<b>Radiology Services</b>	<p>These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.</p>
<b>Refractory Patient</b>	<p>An individual who does not achieve clinical disappearance of the disease after standard therapy.</p>
<b>Relapse</b>	<p>When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.</p>
<b>Remitting Agent</b>	<p>Any individual or organization that has agreed, on behalf of the subscriber, to:</p> <ul style="list-style-type: none"><li>• Collect or deduct premiums from wages or other sums owed to the subscriber and</li><li>• Pay the subscriber's BCBSM bill</li></ul>
<b>Research Management</b>	<p>Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.</p>
<b>Residential Substance Abuse Treatment Program</b>	<p>A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."</p>
<b>Respite Care</b>	<p>Relief to family members or other persons caring for terminally ill persons at home.</p>

**Reversible Treatment**

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

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

**Rider**

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

**Right of Reimbursement**

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

**Routine Patient Costs**

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

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

<b>Screening Services</b>	Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.
<b>Secondary Plan</b>	The health care plan obligated to pay for services after the primary plan has paid for services.
<b>Self-Dialysis Training</b>	Teaching a member to conduct dialysis on himself or herself.
<b>Semiprivate Room</b>	A hospital room with two beds.
<b>Service Area</b>	The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.  <b>NOTE:</b> BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.
<b>Services</b>	Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.
<b>Skilled Care</b>	A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be: <ul style="list-style-type: none"><li>• Ordered by the attending physician</li><li>• Medically necessary according to generally accepted standards of medical practice</li><li>• Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician</li></ul>
<b>Skilled Nursing Facility</b>	A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.
<b>Small Bowel Transplant</b>	A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.

**Special Foods for Metabolic Disease**

Special medical foods that are formulated for the dietary treatment of an inherited metabolic disease. The nutritional requirements of the patient are established by medical evaluation and the diet is administered under the supervision of a physician. These formulations are exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration.

Special infant formulas are liquid feedings used for the treatment of inherited metabolic diseases. These formulas can provide up to 85 percent of the protein, vitamin and mineral needs of an infant.

A low-protein modified food product is one specially formulated to provide less than one gram of protein per serving. It is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a food that is naturally low in protein.

**Specialty Hospitals**

Hospitals that treat specific diseases, such as mental illness.

**Specialty Pharmaceuticals**

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

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

- Drugs administered by home infusion therapy providers
- Drugs administered in the office by health care practitioners

## Section 8: The Language of Health Care

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### **Specialty Pharmaceuticals** (continued)

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

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

### **Specialty Pharmacy**

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

### **Speech and Language Pathology Services**

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

### **Stabilize**

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

### **Stem Cells**

Primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood components including red cells, white cells and platelets.

### **Subrogation**

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

### **Subscriber**

The person who signed and submitted the application for coverage.

### **Substance Abuse**

Taking alcohol or other drugs in amounts that can:

**Substance Abuse**  
(continued)

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

Substance abuse is alcohol or drug abuse or dependence as classified in the most current edition of the “International Classification of Diseases.”

**NOTE:** Tobacco addictions are included in this definition.

**Syngeneic Transplant**

A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient’s identical twin to transplant into the patient.

**Tandem Transplant**

A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and, if the patient’s cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

**T-Cell Depleted Infusion**

A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

**Technical Surgical Assistance**

Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

**NOTE:** Professional active assistance requires direct physical contact with the patient.

**Terminally Ill**

A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

**Therapeutic Shoes**

Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either “off-the-shelf” or custom molded shoes which assist in protecting the diabetic foot

**Total Body Irradiation**

A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

**Treatment Plan**

A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member’s condition as specified in the plan, even if those services are not covered under the patient’s hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member’s physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

## **Section 8: The Language of Health Care**

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<b>Valid Application</b>	An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.
<b>Voluntary Sterilization</b>	Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.
<b>Waiting Period</b>	Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.
<b>Ward</b>	A hospital room with three or more beds.
<b>We, Us, Our</b>	Used when referring to Blue Cross Blue Shield of Michigan.
<b>Working Aged</b>	Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.
<b>Working Disabled</b>	Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.
<b>You and Your</b>	Used when referring to any person covered under the subscriber's contract.

