



Your Benefit Guide



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Welcome

Blue Cross Blue Shield of Michigan (BCBSM) is pleased to provide you and your family with this benefit guide that explains your health care coverage. When you are well informed about your coverage and your health care benefits, you will have the confidence and security that come from knowing that health care coverage is available when you need it.

Please take time to read this benefit guide and familiarize yourself with your health care coverage. By reading each section carefully, you will understand your benefits and know how to use them wisely. You will also be informed about any out-of-pocket expenses that are your responsibility.

For a complete description of your health care coverage, refer to your certificates and riders which are available online. Members without online access can contact Customer Service to obtain copies of their certificates and riders. See the "Customer Service" section for information on contacting us.

When you come across a word you don't understand, look in the Glossary at the back of this benefit guide. It contains the definitions of many words that you might not be familiar with.

Questions?

If you still have questions about your health care coverage, please call your local BCBSM customer service office. You can find the phone number printed on the back of your ID card.



The information contained herein provides a summary of your group's health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to BCBSM certificates, riders, plan modifications and/or changes that your group may be making to your coverage. Please contact your health care administrator or call the customer service phone number printed on the back of your ID card if you have additional questions regarding your health care benefits.

How Your Plan Works

The following are general guidelines about your PPO health care plan. Please refer to your certificate and riders for detailed information regarding the limitations and exclusions of your health care plan.

Referrals

You can self-refer to any PPO provider and remain in-network. However, referrals to **non-network** providers must be **coordinated by your PPO provider** to remain payable at the in-network level of benefits. It is important to remember that a referral **does not guarantee payment**. To be covered, the referred service must still be a covered benefit under your health care plan.

Note: If you are referred to a non-network, nonparticipating provider, you are responsible for any difference between the provider's charge and our approved amount.



Limited network

For certain providers (e.g., certified registered nurse anesthetists and independent licensed physical therapists), BCBSM does not have a PPO network. If you receive services from a provider for which there is no PPO network, the service will be covered at the in-network level of benefits. If you are unsure whether or not there is a PPO network for a service, please contact your local BCBSM customer service office.

Note: For out-of-network providers **payment is based on whether or not they are a BCBSM participating or nonparticipating provider with our Traditional plans.**

Emergency care

When you think emergency care is needed, go to the nearest medical facility. The initial exam to treat a medical emergency or accidental injury is covered at the in-network level of benefits. However, any follow up care that is required is not considered emergency care and is subject to network guidelines.

Experimental services

We do not pay for experimental services. Facility services and physician services, including diagnostic tests related to experimental procedures are also not payable. Please refer to your certificate for an explanation on how we determine experimental services.

Pain management

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

Health*caring* programs

Getting or staying healthy, or learning how to manage a chronic illness, takes a partner — a health*caring* partner — and that's Blue Cross Blue Shield of Michigan. Our personal support programs help you understand the advice and treatment you receive from your physician so you can make the best and most-informed health care choices.

All of our programs are **voluntary and strictly confidential**. Learn more at [Online Health Resources](#).

Healthcare Advisor™

Healthcare Advisor is an online resource that helps you:

- Research and compare drug treatment options, how they are used to treat a condition, and if there are possible interactions with other medications you may be taking
- Select a physician using criteria that are most important to you — including specialty, years of experience and location
- Find and compare hospitals using factors most important to you
- Estimate costs for specific services or tests

Coverage Advisor™

Coverage Advisor is designed to help you, as the key decision maker for your health care coverage, identify the type of health plan that best fits your lifestyle.

Through Coverage Advisor you can calculate your health care costs before they occur, simply by following these three steps:

1. Create a profile for yourself and those covered under your health plan.
2. Estimate your health care use by answering a few questions about medical services expected during the next 12 months.
3. Input basic information about the different plans that you're considering.

The Coverage Advisor calculates your estimated out-of-pocket costs under each selected plan. The format is easy to follow and can be completed within minutes.

BlueHealthConnection®

Whether you're looking for ways to improve your lifestyle or manage a chronic condition, BlueHealthConnection has the support system you need - and it starts with a phone call to BlueHealthConnection at **800-775-BLUE** (2583).

Working together

Good health depends on certain lifestyle choices we make, including what we eat, how active we are, whether or not we smoke and how we manage a chronic illness such as diabetes or high blood pressure. This is where BlueHealthConnection and our health coaches make a healthcaring difference.

When you call BlueHealthConnection, a health coach will work with you by phone to help you decide which level of care you need, such as:

- **General health education** on issues such as smoking-cessation and avoiding the flu
- **Symptom management** and health coaching if you need general advice about medical concerns, and assistance in determining whether and where to obtain care for acute health care problems
- **Quit the Nic**, a smoking-cessation program in which you work one-on-one with a BlueHealthConnection health coach to develop an action plan, set a quit date and stay smoke-free for life
- **Shared decision-making** that includes discussion of options with a health coach or condition-specific, treatment-option videos if you are considering surgery for a significant medical condition
- **Disease management** that includes education and coaching in self-management of chronic illnesses
- **Case management** when you have a medical condition that needs coordination of care
- **Complex case management** for patients who are extremely ill or have terminal conditions

Online health resources

BlueHealthConnection also offers members a private, easy-to-use online resource for personal health and wellness information. The site has a wealth of information on health-related topics and issues and information, all custom-tailored from Michigan's most trusted name in health care, to meet your individual health needs.

Once you log in to the Member Secured Services site, Go to BlueHealthConnection. Here's what BlueHealthConnection online offers you:

- **Health risk appraisal** – This questionnaire, developed by doctors and leading health researchers, takes about 20 minutes to complete. It gives you a clear picture of your overall health status and pinpoints your specific health issues and risks. You can even repeat the health risk appraisal at different intervals to measure changes in your health.
- **Personalized dashboard** – You can create your own personalized home page, called a "health dashboard," that shows you how you can make health changes and suggests ways to reduce risks through education and lifestyle changes.
- **Personal health record** – This tool keeps track of your important health information — including conditions, medications, doctor appointments, emergency information and more.
- **Health information** – From health articles to calculator tools, BlueHealthConnection's interactive tools help you participate with your physician in planning your health goals.
- **Calculator tools** – BlueHealthConnection has interactive tools that can help you learn about general health information and how such factors as body mass affect your and your family's health.

Here are some of the interactive tools you can access online:

- Body mass index calculator
- Children's growth calculator

- ⌘ Target heart rate calculator
- ⌘ Calcium calculator
- ⌘ Calories burned calculator
- ⌘ Heart attack risk calculator

Money-saving programs

Show your Blues ID card to save money through these programs:

BlueSafeSM

This is an injury prevention program that provides you with exclusive discounts on safety products and equipment at various Michigan retailers.

Naturally BlueSM

Show your Blues ID card to receive a 20 percent discount on acupuncture, massage therapy and nutrition counseling from Naturally Blue network practitioners. You can also get discounts on vitamins and herbal supplements.

Weight Watchers[®]

Blues members are eligible for discounts at Florine Mark Weight Watchers locations in northern and southeast Michigan. Take advantage of the Blues' discount at Weight Watchers for a new, healthier you! Your Weight Watchers savings depend on your branch location. Visit bcbsm.com to find the discount information for your county.

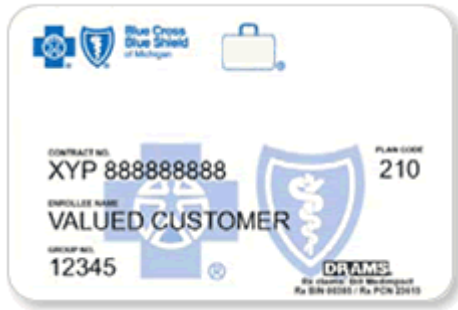
Note: For further information on these programs, visit [Helping Members Save Money](#).

Your BCBSM ID card

This section provides information on using your BCBSM health care plan ID card.

Your Identification card

Once enrolled, you'll receive an ID card similar to the one illustrated below. All cards will show the subscriber's name, even those issued to dependents.



Contract number: The subscriber's assigned contract number with BCBSM.

Plan code: Identifies you as a Michigan BCBS member to out-of-state providers.

Enrollee name: The subscriber's name as it appears on our membership records.

Group number: A unique five-digit group number identifying the sponsors of the health care plan.

About your ID card

- Only you and your eligible dependents may use the cards issued for your contract. Lending your card is illegal and subject to possible fraud investigation and termination of coverage.
- Call us if your card is lost or stolen. Your provider can call us to verify coverage until you receive your new cards.
- Unless you request a replacement card, you will receive new ID cards only when there is a change in your benefit plan.
- If you need additional ID cards, you can order them through [Member Secured Services](#) on [bcbsm.com](#) or by calling your local BCBSM customer service office at the number on the back of your member ID card.

Preventing fraud

If your provider asks for another form of identification, don't worry. Checking a cardholder's identification is just one way our providers help us protect you against unauthorized use of your card.

You can also help prevent fraud by checking your Explanation of Benefit Payments form, or EOB. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it's not and you believe it is fraudulent billing or use of your card, then let us know by calling our antifraud hot line at 800-482-3787. You can also fill out our [online Anti-Fraud form](#) or write to:

Anti-Fraud Unit, Mail Code B759
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd. Detroit, MI 48226

When reporting fraud, **all phone calls and correspondence are confidential.**

Choosing your provider

How much you pay for services you receive depends on whether you use a network or out-of-network network provider. We'll explain the difference below.

What is a network provider?

A network provider is a physician, hospital, or other health care specialist who provides services through our PPO network. PPO network providers have signed agreements with us to accept our approved amount as payment in full for services covered under your health care plan. Using PPO network providers limits your out-of-pocket costs for covered services to any in-network deductible and copayments **that may be** required by your plan.

Special note for parents of students: Dependents attending school away from home still need to choose a PPO physician to remain in-network. (See the section on BlueCard®.)

What is an out-of-network provider?

An out-of-network provider is a physician, hospital, or other health care specialist who has not signed an agreement to provide services through our PPO network. Your health care plan generally has higher out-of-pocket deductible and copays for services received outside the PPO network.

Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible and copayment as payment-in-full for covered services.

Nonparticipating providers have not signed an agreement and **can bill** you for any differences between their charges and our approved amount.

Comparing out-of-pocket costs between network and out-of-network providers

Here is an example of the type of out-of-pocket costs you may incur when you use a PPO network provider versus an out-of-network provider.

You choose a PPO network provider	You choose an out-of-network provider	
	Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> ⌘ Least out-of-pocket cost to you*: <ul style="list-style-type: none"> ⌘ A fixed dollar copay for selected office visits ⌘ Many preventive care benefits are covered at no cost to you ⌘ No balance billings ⌘ No claim forms to file 	<ul style="list-style-type: none"> ⌘ More out-of-pocket costs to you: <ul style="list-style-type: none"> ⌘ An annual deductible ⌘ Percent copay for all services, except emergency visits ⌘ Some services such as preventive care may not be covered out of network ⌘ No balance billings ⌘ No claim forms to file 	<ul style="list-style-type: none"> ⌘ Most out-of-pocket costs to you: <ul style="list-style-type: none"> ⌘ An annual deductible ⌘ Percent copay for all services, except emergency visits ⌘ Some services such as preventive care may not be covered out of network ⌘ Possible balance billings ⌘ Claim forms to file

* Your health care plan may also require in-network deductibles and percent copays. Please refer to the benefit chart for your health care plan requirements.

How providers are paid

Under your health care program, the payment allowed for covered services is called the Blue Cross Blue Shield of Michigan approved amount. Our approved amount is the lower of the provider's billed charge or the BCBSM-maximum payment level for the covered service. Any deductible or copays required by your health care plan **are subtracted from the approved amount** before we make our payment.

PPO network providers — BCBSM sends payment directly to network providers. Because of their signed agreement with BCBSM, network providers will accept this payment as payment in full for covered services. You are only responsible for any in-network deductible or copays **that may be** required by your health care plan.

Out-of-network providers — Unless you have a referral from a PPO network provider, your care is considered out of network. When choosing to go out of network, it is important to verify if the service is covered, **because not all services may be covered out of network.**

When using out-of-network providers, you also need to find out if the provider is participating or nonparticipating with BCBSM. **Here's why this is important:**

- ⌘ **Participating providers** — BCBSM sends payment directly to participating providers. Because of their signed agreement with BCBSM, participating providers will accept this payment as payment in full for covered services. You are responsible only for any out-of-network deductibles or copays required by your health plan.
- ⌘ **Nonparticipating physicians and other professional providers** — BCBSM sends payment directly to you, and it is your responsibility to pay the provider. Because BCBSM's payment to you may be less than the provider's charge, you may also have to pay the provider the difference between our payment and the provider's charge. This would be in addition to any out-of-network deductible or copays required by your health plan.
- ⌘ **Nonparticipating hospitals, facilities and alternatives to hospital care providers** — BCBSM's payment for services received at nonparticipating hospitals is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means that you will need to pay most of the charges yourself, and your bill could be substantial. Please refer to your health care certificate for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.

BlueCard® program



When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you have access to network and participating providers throughout the U.S. and around the world.

And like network and participating providers in Michigan, you won't have to fill out any claim forms or pay up front for the cost of the service unless it's an out-of-pocket cost, such as a deductible or copayment, or a noncovered service.

Here are three steps to make the BlueCard program work for you:

1. In an emergency, go directly to the nearest hospital.
2. Call 800-810-BLUE (2583) or [Search for nearby doctors and hospitals](#).
3. When you arrive at the network or participating provider's office or hospital, present your ID card. The doctor or hospital will recognize the suitcase logo and know that you are receiving services under the BlueCard program. This means they will submit any claim forms and only bill you for any deductible or copay that may be required by your health care plan.

Care out of the U.S.

With our BlueCard program, your coverage also travels with you to foreign countries. When you need care outside of the U.S., follow these five steps:

1. Check your certificate to make sure your international benefits are the same outside of the U.S.
2. If you need to find a provider, call the **BlueCard Worldwide Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
3. **In an emergency**, go directly to the nearest doctor or hospital, then call the BlueCard Worldwide Service Center if you are hospitalized. For **non-emergency** inpatient medical care, you must call the BlueCard Worldwide Service Center to arrange access to a BlueCard Worldwide hospital, to locate a doctor or hospital, or if you need medical assistance.
4. If you need to be hospitalized, call your Blue plan for **precertification or preauthorization**. You can find the phone number on your Blue ID card.



Note: This number is different from the phone number listed above.

5. If the BlueCard Worldwide Service Center arranged your hospitalization, the hospital will file the claim for you. You will need to pay the hospital for the deductible or copay expenses you normally pay.
6. For outpatient and doctor care or inpatient care **not arranged** through the BlueCard Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to BCBSM. Try to get all itemized receipts, preferably in English. We will pay the approved amount for covered services at the rate of exchange in effect on the date of service, minus any deductible or copay that may be required by your plan

Eligibility, enrollment and membership

Your group determines the effective date of your health care plan with Blue Cross Blue Shield of Michigan. If you have questions about the date, please check with your human resource area.

Dependent coverage

Coverage for your dependents is based on the certificates and riders included in your health care plan. For dependent eligibility criteria, refer to your certificates and riders which are available online. Members without online access can contact Customer Service to obtain copies of their certificates and riders. See the "Customer Service" section for information on contacting us.

You can also verify your BCBSM membership records on our Web site in [Member Secured Services](#).

Special enrollment periods

If you decline enrollment for yourself and your dependents (including your spouse) because of other health coverage, you may enroll later in this plan if:

- Your other coverage is terminated because of loss of eligibility, or if employer contributions for the other coverage are terminated — provided that you request enrollment within 30 days after your other coverage or the contribution toward that coverage ends.
- You have a new dependent because of marriage, birth, adoption or placement for adoption — provided you request enrollment within 30 days after the marriage, birth, adoption or placement of adoption.

Note: Loss of eligibility includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It **does not include** loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you decline enrollment because you had COBRA, or Consolidated Omnibus Budget Reconciliation Act continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan because of a loss of eligibility.

To request a special enrollment or obtain more information, please see your human resource area.

Making membership changes

To request a membership change for one of the reasons listed below, you will need to complete and return to your human resource area an *Enrollment/Change of Status Form*.

- Name or address change
- Adding or removing a dependent
- Cancellation of your contract
- Medicare eligibility and enrollment

To avoid delays in payments, misdirected communications or potential coverage problems, it's important that you return this form **within 30 days** of when the event occurs. This is especially important **when adding or removing a dependent from your contract because you can be liable for claims paid in error**. For example, in the case of divorce, if you fail to give timely notice you may be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

Continuing coverage on your own

Coverage ends for you and your dependents when you are no longer eligible for coverage through your group. However, you may continue coverage under one of these options:

- Continue **temporary** coverage through COBRA
- Convert to BCBSM's individual coverage, called "group conversion"

For an explanation of COBRA and group conversion coverage, refer to your certificates and riders which are available online. Members without online access can contact Customer Service to obtain copies of their certificates and riders. See the "Customer Service" section for information on contacting us.

You will need to contact your human resource area to clarify eligibility dates and to select the type of coverage that will best meet your needs.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods for pre-existing conditions that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of creditable coverage. You also may request a certificate for health coverage periods on and after July 1, 1996, at any time during your coverage or within 24 months after loss of coverage. To request a certificate of creditable coverage, please call BCBSM at 800-292-3501.

Customer service

Our goal is to provide excellent service. When you call, please be ready to tell us your contract number; and if you're inquiring about a claim, we'll also need the following information:

- ⌘ Patient's name
- ⌘ Provider's name (hospital, doctor, laboratory, other)
- ⌘ Date of service and type of service (surgery, office call, X-ray, other)
- ⌘ Provider's charges

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. For example, **we never release your health information to anyone, unless you have authorized us in writing to do so.** You can find the necessary [release documents and forms](#) on our Web site.

Calling us



To call us, please use the phone number **printed on the back of your ID card.** You can also find this number on your Explanation of Benefit Payments, or EOB. Our customer service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

Hearing- or speech-impaired members, please call:

Area codes 248, 313, 586, 734, 810 and 947

313-225-6903

Area codes 231, 269 and 616

800-867-8980

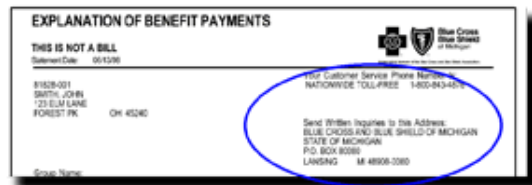
Writing to us

To write us, please use the address in the upper right-hand corner of your EOB. If you do not have an EOB, please send your inquiry to:

Customer Service Center
Blue Cross Blue Shield of Michigan
P.O. Box 2888
Detroit, MI 48231

Or

West Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
P.O. Box 894
Grand Rapids, MI 49518



Receive your Explanation of Benefit Payments statement electronically

From the secured area of our web site, you can view, save or print your EOB statements. Visit [Member Secured Services](#) to sign up for this feature.

Come see us

[Visit one of our walk-in customer service centers](#) for personal, face-to-face service.

Claims information

With the Blues' extensive network of participating providers and our BlueCard® program, the only time you may have to file your own claims is if you receive services from a nonparticipating or non-network provider.

Filing a claim

If you receive services from a nonparticipating or non-network provider, first ask the provider if he or she will bill us for the services. Most providers, even those who do not participate with BCBSM, will submit claims to their patients' insurance companies when asked.

If your provider will not bill BCBSM for you, then follow these steps:

Ask the provider for an itemized statement or receipt with the following information:

1. Name and address of provider *
2. Full name of patient
3. Date of service
4. Provider's charge
5. Diagnosis and type of service

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

Make a copy of all items for your files, and send the originals to us at the address listed in *Where to Write Us*. It is important that you file claims promptly because most services have claims filing limitations.

	PHYSICIAN RECEIPT		
1. Name and address of provider*	① George S. Smith, M.D. 100 Market Street Hometown, USA		
2. Full name of patient	For professional services to: John Doe ②		
3. Date of service	③	④	⑤
	DATE OF SERVICE	CHARGE	DIAGNOSIS/SERVICE
4. Provider's charge	05-31-XX	\$50.00	Anemia/Office Visit
5. Diagnosis and type of service	06-11-XX	\$175.00	Sprained Ankle/X-Ray
	07-26-XX	\$25.00	Anemia/CBC

When payment is made, it will be made directly to the subscriber

Your Explanation of Benefits

After we process claims for services you receive, we send you an Explanation of Benefit Payments (EOBP). The EOBP is not a bill. It is a statement that helps you understand how your benefits were paid. At the top of the EOBP you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for inquiries.

Receive your EOBP electronically

From the secured area of our web site, you can view, save or print your EOB statements. Visit [Member Secured Services](#) to sign up for this feature.

About your EOBP

Briefly your Explanation of Benefit Payments tells you:

- The person who received the services
- The date services were provided ("claims processed from...to...").
- **"Summary of Balances"** includes the provider(s) of the services, and payments, including the amount saved by using Network providers.
- **"Summary of Deductibles and Copayments"** provides your deductible and copayment requirements as well a total of all deductibles and copayments paid to date.
- **"Helpful Information"** includes messages and reminders.
- **"Detail on Services"** summarizes the BCBSM payment and shows your balance.

If you see an error contact your provider first. If they cannot correct the error, call the customer service number on your EOBP.

[View an example of our EOBP form \(pdf\)](#)

EXPLANATION OF BENEFITS PAYMENTS



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

THIS IS NOT A BILL

Statement Date: 06/13/XX

37239-001
Smith, John
123 Elm Lane
Livonia MI 48152

Group Name: ABC COMPANY
Group Number: 68754321
Subscriber Name: SMITH, JOHN
Contract Number: 999000111
Coverage: HOSPITAL PHYSICIAN

Patient Name or Initial: SUSAN
Patient Birth Month/Year: 09/61

Your Customer Service Phone Number is:
NATIONWIDE TOLL-FREE 1-800-637-2227

Send Written Inquiries to this Address:
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
P.O. BOX 2990
DETROIT MI 48226-2998

See your Health Benefits Certificate or Benefits Guide for details on contract coverage.

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-)	Less BCBSM Paid	(-)	Less Participating Provider Savings	(-)	Less Other Insurance Paid	(-)	Equals Your Balance*
DOE, B MD	184.00		60.14		117.18		0.00		6.68
Totals \$	184.00	\$	60.14	\$	117.18	\$	0.00	\$	6.68

*Note: The amounts in the "Equals Your Balance" column includes any copayments, deductibles, sanctions, and non-covered charges.

Summary of Deductible and Copayments

(These totals are based on our information to date and may not reflect all outstanding claims.)

Totals for: FAMILY	01/01/XX to 12/31/XX	Totals for: SUSAN	01/01/XX to 12/31/XX
Deductible required for year:	\$ 200.00	Deductible required for the year:	100.00
Deductible applied year to date:	\$ 200.00	Deductible applied year to date:	100.00

The family deductible requirement has been met.
The patient deductible requirement has been met.

Totals for: FAMILY	01/01/XX to 12/31/XX	Totals for: SUSAN	01/01/XX to 12/31/XX
Copayment required for year:	\$ 1000.00	Copayment required for year:	1000.00
Copayment applied year to date:	\$ 400.00	Copayment applied year to date:	200.00

The family copayment requirement has not been met.
The patient copayment requirement has not been met.

Helpful Information

What sets the Michigan Blues apart from some other insurers? The others may drop you when you get sick – or charge you higher premiums. We think that's unfair. The Blues have never done it, and never will.

Details on Services

Contract Number: 999000111

Patient: SUSAN

Service Date (From/To): 06/04/XXXX	Total Charge	\$ 184.00
Claim Record On: 06/07/XXXX	Amount Approved by BCBSM for this service	66.82
Provider Name: DOE B MD	Minus deductible	- 6.68
Provider Status: PARTICIPATING	BCBSM processed on 10/09/XX and paid prior.....	60.14
Referring Provider:	Savings because provider participates with BCBSM.....	+ 117.18
Service Type: SURGERY	Total Covered	\$ 177.32
Procedure: SHAVE SKIN LESION		
Procedure Code: 11300	Your Balance (Highlighted Amount)	\$ 6.68
Claim Number: 4160871234		

Coordination of benefits

Coordination of Benefits, or COB, is how health care carriers coordinate benefits when you are covered by more than one health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your BCBSM health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

How COB works

If you are covered by more than one group plan, COB guidelines determine which carrier pays for covered services first.

- Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.
- Your secondary plan is responsible for paying after your primary plan has processed the claim.

Note: To the extent that the services covered under your health care plan are also covered and payable under another group health care plan, we will combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

Filing secondary COB claims

Ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to BCBSM.

Updating COB information is your responsibility

You can avoid claims-processing delays if you keep your COB information up to date. View your current COB information in [Member Secured Services](#).

If you need to change the information we have on record, notify your employer immediately. We may also periodically ask you to update your COB information through a letter of inquiry. Please help us serve you better by responding quickly to the letter.

Subrogation

Your contract with Blue Cross Blue Shield of Michigan includes a provision called "subrogation." If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows Blue Cross Blue Shield of Michigan to hold a party that caused an injury or condition to be responsible for payment of the medical expenses related to the injury.

For example: A Blues member is injured in a store, or other commercial property, due to negligence on the part of the store or property. BCBSM pays for the services to the injured person, as required by their health care contract. Later the member sues the store. The Blues' subrogation unit would attempt to recover the money paid for medical services in that lawsuit.

The types of cases we pursue generally fall into the following categories:

- ⌘ Workers' compensation
- ⌘ Personal injury
- ⌘ Medical malpractice

Please remember that if you hire an attorney to represent you in such a situation, you should always have your attorney call Blue Cross Blue Shield of Michigan at 517-322-8177.

Frequently asked questions and answers about your PPO plan

How can I find a PPO doctor?

To find a doctor you can [access the directory](#) or call our customer service office. Once you've found a doctor, you can then make an appointment with that physician.

What happens if I don't like the PPO doctor I select?

If don't like the physician you selected, simply choose another one. You are not required to notify Blue Cross when you select or change network providers.



Do I have to use PPO providers?

No. You have the freedom to choose any physician or hospital for the care you need. However, if you receive services from a provider not in the PPO network, you are responsible for paying any applicable out-of-network costs required by your plan. In addition, you may be required to pay an additional charge if the provider you visit is not only outside the network, but does not participate with Blue Cross Blue Shield of Michigan. A nonparticipating provider may choose not to accept our approved amount as payment in full for a covered service. In that case, you would be responsible for paying the difference between the provider's charge and our approved amount, in addition to any out-of-network charges. We encourage you to ask the provider if he or she participates with us before you receive services.

What is an Out-of-network charge?

An out-of-pocket cost is a deductible and/or copayment that you are responsible for paying under your plan when you choose to go to a provider outside the PPO plan network.

What if my doctor sends me to a provider outside the network?

The PPO network is designed to meet all your health care needs, including care by specialists. However, in the rare event that a particular service or specialty is not available in the network, your PPO provider may refer you outside the network. When you have a referral from your network provider, we will pay for the covered services that you receive according to your level of coverage under your contract without any out-of-network costs to you.

Note : If you are referred to a non-network, **nonparticipating** : provider, you are responsible for any difference between the provider's charge and our approved amount.

When I travel outside of Michigan, am I still covered?

Yes. When traveling **outside of Michigan**, your coverage travels with you. Through the BCBSM BlueCard program, you have access to network and participating providers **throughout the U.S. and around the world.** And like participating providers in Michigan, you won't have to fill out any claim forms or pay up front for the cost of the service unless it is an out-of-pocket cost, such as a deductible or copay or a non-covered service. When you need medical care while traveling, simply call 1-800-810-BLUE and you will be referred to the nearest Blue PPO provider or Blue participating provider if there are no PPO providers nearby.

What if I need to go to the emergency room?

A medical emergency is a condition that occurs suddenly and unexpectedly, and could result in serious bodily harm or threaten life unless treated immediately. Examples include:

- Heart attack or stroke
- Inability to breathe

An accidental injury is caused by an action, object or substance outside of the body. Examples are:

- Overdosing on medicine or swallowing poison
- Allergic reaction
- Inhaling smoke, carbon monoxide or fumes

Emergency room services for medical emergencies and accidental injuries are covered when the lack of immediate medical attention could result in serious jeopardy to your health or when pre-authorized by your primary care physician. However, there may be limited or no payment for emergency room services that do not meet these standards.

Here's what to do if you have a medical emergency or accidental injury:

- Always follow the advice of your primary care physician.
- If you have an immediate and unforeseen medical emergency and the time to contact your primary care physician may mean permanent damage to your health, you should go directly to the nearest emergency room or call 911 for assistance.
- It is suggested (but not required) that you, the hospital, or someone acting for you notify your doctor within 48 hours or as soon as it is medically reasonable to do so.
- You should also contact your primary care physician for any follow-up care.

What should I do if I lose my Blue Cross Blue Shield ID card?

We'll replace it without charge. Just call a customer service representative or log in to our Web site at bcbsm.com and click on I am a Member. You'll be able to order new ID cards at no charge.

I will be retiring soon and will go on Medicare. What will happen to my PPO coverage?

Your PPO Plan does not cover individuals on Medicare. At the time you become eligible to enroll in Medicare, your employer will offer you another health care plan that will supplement the coverage provided by Medicare. If this is currently a concern for you, ask your employer now about these health care options.

I have no-fault auto coverage. If I am injured in an auto accident, will my PPO plan cover my medical bills?

If you are involved in a vehicle accident, payment for any medical services you receive will be coordinated between Blue Cross and your auto insurance carrier as required by law or set forth in the carrier's contracts. Always inform your provider if your illness or injury is related to an auto accident. That way we can properly coordinate payment with your auto insurer.

What if my claim is rejected or denied?

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, we will notify you of the denial in writing. To appeal the denial or payment, you may either call or write to us using the number or address on the back of your BCBSM ID card. Be sure to state the reason for your appeal and furnish us with all information that supports your appeal. We will review your appeal and respond to you within 60 days after we receive it.

For more information on the appeals process and what you must do, please refer to your member handbook or our

Web site at bcbsm.com.

How can I obtain additional information about my doctor's professional education and number of years in practice?

[The Healthcare Advisor](#)™ is our online resource that can help you research a physician including specialty, years in practice or experience, and location.

Glossary

This section explains the terms used in your Certificates and Riders.

Accidental Injury

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

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

Acute Care

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

Acute Care Facility

A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

Administrative Costs

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

Allogeneic (Allogenic) Transplant

A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.

Ambulatory Surgery

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.

Ambulatory Surgery Facility

A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.

Ancillary Services

Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary

care the patient receives. They do not include room, board and nursing care.

Approved Amount

The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

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.

Autologous Transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM

Blue Cross Blue Shield of Michigan.

Benefit Period

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

Biological

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

Birth Year

A 12-month period of time beginning with a child's month and day of birth.

BlueCard PPO Program

A program that allows Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

BlueCard Worldwide Program

A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

Blue Cross Plan

Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan

Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

Calendar Year

A period of time beginning January 1 and ending December 31 of the same year.

Carrier

An insurance company providing a health care plan for its members.

Certificate

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

Certified Nurse Midwife

A nurse who provides some maternity services and who:

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

Certified Nurse Practitioner

A nurse who provides some medical services and who:

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

Certified Registered Nurse Anesthetist

A nurse who provides anesthesiology services and who:

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

Chronic Condition

A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

Clinical Trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this Certificate clinical trials include:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Colony Stimulating Growth Factors

Factors that stimulate the multiplication of very young blood cells.

Congenital Condition

A condition that exists at birth.

Contraceptive Medication

Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract

This Certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Conventional Treatment

Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

Coordination Period

A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

Copayment

The portion of the approved amount that you must pay for a covered service after your deductible, if required, has been met.

Covered Services

The services, treatments or supplies identified as payable in your Certificate.

NOTE: To be payable, covered services must be medically necessary, as defined in this section.

Custodial Care

Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible

The amount that you must pay for covered services, under any certificate, before benefits are payable.

Dental Care

Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

Designated Facility

To be a covered benefit, human organ transplants must take place in a "BCBSM-designated" facility. A designated facility is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of

designated facilities and will make it available to you and your physician upon request.

Designated Payment Level

The amount used to calculate your BCBSM copayment under the BlueCard Program. This amount is the lesser of:

- The provider's billed charges for covered services or
- An amount based on such factors as agreements with the Host Plan's provider community or historical average reimbursement levels

NOTE: BlueCard Program policies permit Host Plans to adjust negotiated prices going forward to correct for overestimation or underestimation of past prices. However, the designated payment level used to calculate your BCBSM copayment is considered a final price.

Some state laws require that a special calculation be applied to determine the Host Plan's payment. In such instances, the designated payment level will reflect any statutory requirements in effect at the time you receive care.

Detoxification

The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Development Condition

A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Dialysis

The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

Direct Supervision

The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Diversional Therapy

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

Dual Entitlement

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

Durable Medical Equipment

Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective Date

The date your coverage begins under this contract. This date is established by BCBSM.

Eligibility

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

End Stage Renal Disease (ESRD)

Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

Enrollment Date

The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)

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

Exclusions

Situations, conditions, or services that are not covered by the subscriber's contract.

Experimental Treatment

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

Facility

A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening

A laboratory test to detect blood in feces or stool.

First Degree Relative

An immediate family member; that is, a mother, father, sister or brother.

First Priority Security Interest

The right to be paid before any other person from money recovered in a verdict, judgment, or settlement of a legal action or settlement that is not part of a legal action.

Flexible Sigmoidoscopy

A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Freestanding Outpatient Physical Therapy Facility

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

Group

A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have several groups (different benefits for different groups of employees working for the same employer). A group can also include members who are associated with the same organization.

Gynecological Examination

A history and physical examination of the female genital tract.

Hazardous Medical Condition

The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health Maintenance Examination

A comprehensive history and physical examination including blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hemodialysis

The use of a machine to clean wastes from the blood after the kidneys have failed.

High Dose Chemotherapy

A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high dose chemotherapy is given.

High Risk Patient

An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Hospice

A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital

A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and
- Is fully licensed and certified as a hospital, as required by all applicable laws and
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons

and registered nurses.

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

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

Host Plan

A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state.

Independent Physical Therapist

A licensed physical therapist who is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.

Infusion Therapy

The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

Injectable Drugs

Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

Irreversible Treatment

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

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- The treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
 - Crowns, inlays, caps, restorations and grinding
 - Orthodontics, such as braces, orthopedic repositioning and traction
 - Installation of removable or fixed appliances such as dentures, partial dentures or bridges
 - Surgery directly to the jaw joint
 - Arthrocentesis

Jaw Joint Disorders

These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

Lien

A first priority security interest in any money, or in any action to recover money for the treatment of injuries for which we paid benefits.

Lobar Lung

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

Long-Term Acute Care Hospital

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

Mammogram

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

Mandibular Orthotic Reposition Device

An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care

Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis

A custom made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical Emergency

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

Medical Evidence Report

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

Medically Necessary

A service must be medically necessary to be covered. There are two definitions; one applies to physician services and one applies to hospital services.

■ Medical necessity for payment of physician services:

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

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

⌘ **Medical necessity for payment of hospital and LTACH services:**

Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

- ⌘ The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
 - ⌘ The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
 - ⌘ **Appropriate** means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
 - ⌘ For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
 - ⌘ The service is not mainly for the convenience of the member or health care provider.
 - ⌘ The treatment is not generally regarded as experimental by BCBSM.
 - ⌘ The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).
-

Member

Any person eligible for health care services under this Certificate. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

Nonpanel Providers

Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

Nonparticipating Providers

Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational Therapy

A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- ⌘ Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery
 - ⌘ Help the patient learn to apply the newly restored or improved function to meet the demands of daily living, or
 - ⌘ Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, shower chairs, large-handle eating utensils, lap trays and raised toilet seats)
-

Off-Label

The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.

Orthopedic Shoes

Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic Device

An appliance worn outside the body to correct a body defect of form or function.

Outpatient Mental Health Facility

A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

Outpatient Substance Abuse Treatment Program

A program that provides medical and other services on an outpatient basis specifically for substance abusers.

Panel Providers

Hospitals, physicians and other licensed facilities or health care professionals who provide services through this PPO program. Panel providers have agreed to accept our approved amount as payment in full for covered services provided under this PPO program.

Pap smear

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

Partial Liver

A portion of the liver taken from a cadaver or living donor.

Participating PPO Provider

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

Participating Providers

Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Patient

The subscriber or eligible dependent that is awaiting or receiving medical care and treatment.

Per Claim Participation

Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral Blood Stem Cell Transplant

A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.

Peritoneal Dialysis

Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis

Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Therapy

The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due

to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:

- Muscle strength
 - Joint motion
 - Coordination
 - General mobility
-

Physician

A doctor of medicine, osteopathy, podiatry, chiropractic or dentistry.

Preexisting Condition

A condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.

Preferred Provider Organization

A limited group of health care providers who have agreed to provide services to BCBSM members enrolled in the PPO program. These providers accept the approved amount as payment in full for covered services.

Presurgical Consultation

A consultation that allows a member to get an additional opinion from a physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon when surgery is recommended.

Primary Payer

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

Primary Plan

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

Professional Provider

One of the following:

- Doctor of Medicine
 - Doctor of Osteopathy
 - Podiatrist
 - Chiropractor
 - Fully licensed psychologist
 - Dentist
-

Prosthetic Device

An artificial appliance that:

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

Provider

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

Psychiatric Day Treatment

Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.

Psychiatric Night Treatment

Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.

Psychologist

A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging

A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified Beneficiary

Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualifying Event

One of the following events that allows a qualified beneficiary to receive COBRA coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
 - Death of the employee
 - Divorce
 - Loss of dependent status due to age, marriage, change in student status, etc.
 - The employee becomes entitled to coverage under Medicare
-

Radiology Services

These include X ray exams, radium, radon, cobalt therapy, ultra sound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Refractory Patient

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

Relapse

When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

Remitting Agent

Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber and

- Pay the subscriber's BCBSM bill
-

Research Management

Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

Residential Substance Abuse Treatment Program

A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care".

Respite Care

Relief to family members or other persons caring for terminally ill persons at home.

Reversible Treatment

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

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
 - This treatment is not intended to cause permanent change to a person's bite or position of the jaws.
 - This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:
 - Arthrocentesis
 - Physical therapy (see page 4.14 for physical therapy services)
 - Reversible bite splint appliances (mandibular orthotic reposition devices)
-

Rider

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

Rx Only

A drug that requires a prescription under federal law.

Screening Services

Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

Secondary Plan

The health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training

Teaching a member to conduct dialysis on himself or herself.

Semiprivate Room

A hospital room with two beds.

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

Skilled Care

A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- Ordered by the attending physician
 - Medically necessary according to generally accepted standards of medical practice
 - Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician
-

Skilled Nursing Facility

A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Small Bowel Transplant

A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.

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.

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.

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 right to recover payment when another person, insurance company or organization may be legally obligated to pay for health care services that the Blues have already paid; for example, in the case of a court judgment.

Subscriber

The person who signed and submitted the application for coverage.

Substance Abuse

Taking alcohol or other drugs in amounts that can:

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

Substance abuse is alcohol or drug abuse or dependence as classified in Categories 303.3 – 305.0 and 305.2 – 305.9 of the most current edition of the International "Classification of Diseases."

Substance Abuse Treatment Program Services

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

Syngeneic Transplant

A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

Tandem Transplant

A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

T-Cell Depleted Infusion

A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Technical Surgical Assistance

Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

NOTE: Professional active assistance requires direct physical contact with the patient.

Terminally Ill

A state of illness causing a person's life expectancy to be six 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 integrated case and disease management. The treatment plan may include medically necessary services that BCBSM determines should be provided 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.

Valid Application

An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Waiting Period

Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

Ward

A hospital room with three or more beds.

We, Us, Our

Used when referring to Blue Cross Blue Shield of Michigan.

Well-Baby Care

Services provided in physician's office to monitor the health and growth of a healthy child.

Working Aged

Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

Working Disabled

Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your

Used when referring to any person covered under the subscriber's contract.

Your right to file an Internal Grievance and to request an Independent External Review

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our Customer Service Representatives. You can locate the phone number in the top right hand corner of the first page of your Explanation of Benefits statement or in the letter we send to notify you that we have not approved a request for benefits. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing an internal grievance procedure, including a managerial-level conference, if you believe that we have violated **Section 402 or 403 of Public Act 350**.

You will find the specific provisions of those two parts of the act at the end of this section. Public Act 251 of 2000 provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced, or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

Internal grievances

A. Standard internal grievance procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance under the grievance procedure, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example your doctor or hospital. The standard internal grievance procedure is as follows:

1. You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment. Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting. We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.
2. If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing. Mail your request to:

Conference Coordination Unit

Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MI 48231-2459

You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.

3. If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, (plus any time you may have taken under the grievance procedure or that we were allowed to take to obtain information from your provider), you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information found above, you should also know:

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal grievance procedure.

- b. Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- c. You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.

B. Expedited internal grievance procedure

If a physician substantiates orally or in writing that adhering to the timeframe for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is as follows:

1. You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone by calling (313) 225-6800. We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.
2. If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Commissioner. In addition to the information found above, you should also know:
 - a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure.
 - b. If our decision is communicated to you orally, we must provide you with written confirmation within 2 business days.

External reviews

A. Standard External Review Procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative has the right to request an external review from the Commissioner. The standard external review process is as follows:

1. Within 60 days of the date you either received our final determination or should have received it, send a written request for an external review to the Commissioner. Mail your request, including the required forms that we will supply to you, to:

Michigan Division of Insurance

Benefit Inquiry Section
Post Office Box 30220
Lansing, MI 48909

2. If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review.

You will have an opportunity to provide additional information to the Commissioner within 7 days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within 7 business days after we receive notice of your request from the Commissioner. The assigned Independent Review Organization will recommend within 14 days whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within 7 business days whether or not to accept the recommendation and will notify you.

The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent

Review Act.

3. If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review. The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision, and the Commissioner's decision is your final administrative remedy under Public Act 350.

B. Expedited External Review Procedure

If a physician substantiates orally or in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and if you have filed a request for an expedited internal grievance, you may request an expedited external review from the Commissioner. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

1. Within 10 days of your receipt of our denial, termination, or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Commissioner. To do so in writing, mail your request, including the required forms that we will supply to you, to:

Michigan Division of Insurance

Benefit Inquiry Section
Post Office Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll-free number: 1-877-999-6442

2. Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you.

The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Sections 402 and 403 of Public Act 350

What we may not do

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

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
- Refuse to pay claims without conducting a reasonable investigation based upon the available information.

- ⌘ Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
- ⌘ Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.
- ⌘ Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
- ⌘ Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage.
- ⌘ Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.
- ⌘ Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of, the subscriber under whose certificate the claim is being made.
- ⌘ Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.
- ⌘ Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.
- ⌘ Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

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

The things we cannot do under this section are:

- ⌘ Issue or deliver to a person, money or other valuable consideration.
- ⌘ Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
- ⌘ Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
- ⌘ Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.
- ⌘ Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person.

What we must do

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim. We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

Disclosure required by the Patient Protection Act

Upon enrollment, we must provide subscribers, in plain English, a written description of the terms and conditions of Blue Cross Blue Shield of Michigan's certificate. The form must list all information that is available to the member upon request. The following information is available to you by calling or writing the Customer Service office at the number or address listed on the inside front cover of this book. You can request:

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