Dental, Vision and Hearing Benefits Certificate for Blue Cross Individual Medicare Supplement℠

Blue Cross Blue Shield of Michigan 30-Day Money-Back Guarantee

Blue Cross Blue Shield of Michigan is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCBSM in writing within 30 days of the effective date of your coverage. You will receive a full refund of your premium. Please see the "How to Reach Us" section of this certificate for our mailing address and Customer Service telephone numbers.

2025

READY TO HELP

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

Your dental, vision and hearing coverage provide many benefits for you. These benefits are described in this book, which is your **certificate**.

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

If you have any questions about your coverage, please call us at one of the BCBSM Customer Service telephone numbers listed on the back of your BCBSM ID card or log into your Member Account at www.bcbsm.com.

About Your Certificate

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

- **Table of Contents** — for quick reference
- **Information About Your Contract**
- **Dental Services**
- **Vision Services**
- **Hearing Services**
- **General Conditions of Your Contract**
- **Definitions** — explanations of the terms used in your certificate
- **Additional Information You Need to Know**
- **Index**

This certificate provides you with the information you need to get the most from your BCBSM dental, vision and hearing care coverage.

This certificate refers to you as the **subscriber** because the contract is in your name.

The term **member** refers to you when you are enrolled in a BCBSM Medicare Supplement Plan with dental, vision and hearing and you receive benefits under this certificate.

We hope this certificate provides you with the information you need to get the most from your BCBSM Medicare dental, vision and hearing coverage. Please call us if you have any questions.

Table of Contents

Section 1: Information About Your Contract

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

- **ELIGIBILITY**
  - Who Is Eligible for Blue Cross Dental, Vision and Hearing Coverage
- **CONTRACT DATES**
- **BILLING**
  - Information About Your Bill
  - Increases in Premiums
- **TERMINATION**
  - How to Terminate Your Coverage
  - How We Terminate Your Coverage
  - Rescission

ELIGIBILITY

Who Is Eligible for Blue Cross Dental, Vision and Hearing Coverage

To be eligible for coverage under this certificate, you must:

- Be enrolled in a Blue Cross Blue Shield of Michigan Medicare Supplement Plan
- Not be enrolled in any other individual dental, vision or hearing coverage

CONTRACT DATES

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

BILLING

Information About Your Bill

Each bill applies to one month of coverage.

You must make your payment by the due date printed on your bill. When we receive your payment, we automatically renew your coverage. If your payment covers more than one month, we renew your coverage for each month covered by the payment.

If we do not receive your payment by the due date, we will allow you a grace period of 30 days during which we will send you a final bill. However, your coverage will not continue during the grace period.

- If we receive your payment during the grace period, your coverage will be reinstated without a lapse.
- If we do not receive your payment during the grace period, your coverage will be terminated. If you wish to reenroll you must wait until the following February 1 through April 30 enrollment period.

Increases in Premiums

- We may also raise your premium each year.
- If we raise the premiums, we will give you 30 days prior written notice.

TERMINATION

How to Terminate Your Coverage

Call or send BCBSM your written request to terminate coverage at the phone number or address listed in this certificate. We will accept termination of your coverage only from you. Your coverage will then be terminated as of the date you requested or at the earliest date possible. All benefits under this certificate will end.

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

How We Terminate Your Coverage

We will terminate your coverage if:

- You are no longer eligible for Medicare coverage.
- You no longer have coverage under a BCBSM Medicare Supplement Plan.
- You do not pay your bill on time.
- You are serving a criminal sentence for defrauding BCBSM.
- You **misuse** your coverage.

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

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

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

Your coverage will end on the last day covered by your last payment.

Termination (continued)

Rescission

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

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

We may rescind your coverage back to the effective date of your contract. If we do, we will provide you with a 30-day notice. Once we notify you that we are rescinding your coverage, we may hold or reject claims during this 30-day period. You must repay BCBSM for its payment for any services you receive.

Section 2: Dental Services

This section describes the services we pay for and the extent to which they are covered. We pay for services when they are provided according to this Certificate.

To be covered, services must be:

- Dentally necessary and
- Performed by a dentist or, where applicable,
- Performed by a dental hygienist under the supervision of a dentist.

What You Must Pay

Cost-Sharing Chart	
PPO (In-Network) Dentists	
Deductible	None
Coinsurance	0% for Class I – Diagnostic and Preventive Services 50% for Class II – Basic Services
Annual Benefit Maximums	$1,500 for PPO (in-network) and non-PPO (out-of-network) Class II – Basic Services combined
Non-PPO (Out-of-Network) Dentists	
Deductible	None
Coinsurance	50% for Class I – Diagnostic and Preventive Services 50% for Class II – Basic Services
Annual Benefit Maximums	$1,500 for PPO (in-network) and non-PPO (out-of-network) Class II – Basic Services combined

Dental Services We Pay For

Class I – Diagnostic and Preventive Services

- Diagnostic and preventive services – evaluate existing conditions, prevent oral disease and stop the progress of disease already present. These services include:
  - Periodic oral examinations/evaluations
  - Prophylaxes
  - Fluoride treatments
- Bitewing radiographs (X-rays) and individual periapical films – as needed for routine care or to detect specific conditions.
- Oral brush biopsy sample collection – identifies cancerous and precancerous cells.

We Pay For (continued)

Class II – Basic Services

- Minor restorative services – repair decayed or damaged teeth. These services include:
  - Amalgam and resin-based composite fillings and fillings of similar materials
  - Recementation or repair of posts, crowns, veneers, inlays and onlays
- Simple extractions
- Non-surgical endodontic services – treat teeth with diseased or damaged nerves. These services include:
  - Root canal treatments on permanent teeth and on primary teeth without permanent successors
- Major restorative services – repair decayed or damaged teeth. These services include:
  - Crowns when a tooth cannot be restored with materials such as amalgam or resin-based composite fillings

Limitations

The limitations on covered dental services are described below. We will pay for:

- Periodic oral examinations/evaluations – twice every calendar year.
- Prophylaxes (cleanings) – twice every calendar year.
- X-rays – either a set (up to four films) of bitewing X-rays once every two calendar years or individual periapical films (up to six) once every two calendar years.
- Fluoride treatments or topical fluoride varnishes – once every calendar year.
- Oral brush biopsy sample collection – once every calendar year.
- Amalgam and resin fillings – once per tooth every 48 months.
- Root canals – once per tooth per lifetime.
- Crown for permanent teeth – once per tooth every 84 months.

Exclusions

The following services are **not** covered under this certificate. You are responsible for paying the charges for these services:

- We do not pay for any services that are not listed in this certificate as payable.
- We do not pay for services that are covered by Medicare.

How Dental Benefits Are Paid

Choosing A Dentist
You may choose any dentist. However, your out-of-pocket cost is less when you select a Blue Dental Tier 1 PPO (in-network) dentist.

Our payment will vary based on whether your dentist is a:

- **Tier 1 PPO (In-Network) Dentist** – A dentist who has signed a PPO contract and agrees to accept our approved amount as full payment for covered services.
- **Tier 2 Participating Non-PPO (Out-of-Network) Dentist** – A non-PPO (out-of-network) dentist who participates with us on a per-claim basis and agrees to accept our approved amount as full payment for covered services.
- **Nonparticipating Dentist** – A non-PPO (out-of-network) dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amount as full payment for covered services. A nonparticipating dentist may bill you for the difference between what we paid you for covered services and the amount they charge.

If you choose to get services from a nonparticipating dentist, you will have to pay the difference (if there is any) between what we pay and what the dentist charges.

Please see the subsection titled, "*Paying for Services*" for more information about how we pay your dental claims.

How Dental Benefits Are Paid (continued)

Predetermination of Benefits
Your dentist may, but is not required to, submit their treatment plan to us for predetermination before providing you with certain complex or expensive services. We will review the plan before the services are performed and let you and your dentist know whether the planned services will be covered and how much we will pay for them.

If we determine that an alternative treatment will produce acceptable results at a lower cost, the most we will pay is our approved amount for the alternative treatment. If you and your dentist choose the treatment plan that was submitted by your dentist, you can apply the amount we approve for the recommended alternative to the original plan. However, you will be responsible for any difference in cost.

Predetermination is **not** a guarantee of payment. Our payment for predetermined services is based on the benefits that are available to you on the date the services are actually provided, and on the requirements, terms and conditions of this certificate.

An approved predetermination is valid for 12 months. If the services have not been completed within that time, you can ask for a new predetermination.

Filing Claims
Within 24 months of the date services were completed, you or your dentist must file a claim for benefits on our required form before we pay covered services. The dentist must certify that services were provided as billed. We have the right to deny payment for services if we have not received a claim for those services within 24 months of the date they were completed.

For some procedures, we require documentation such as:

- X-rays
- Models of the teeth and jaw or
- A written explanation as to why the procedures were needed

A BCBSM dental consultant reviews this documentation to determine dental necessity.

How Dental Benefits Are Paid (continued)

Paying for Services
We pay for covered dental services performed in and outside the state of Michigan. Below is a description of how we pay for covered services.

- Tier 1 PPO (In-Network) Dentists:
  Tier 1 PPO (in-network) dentists agree to accept our approved amount as payment in full for covered services. We pay Tier 1 PPO (in-network) dentists directly. You are responsible for cost sharing amounts required by your plan, as well as any charges for non-covered services. Our approved amounts for Tier 1 PPO (in-network) dentists are generally lower than our approved amounts for non-PPO (out-of-network) dentists, so the cost-sharing amount you are responsible for may also be lower.

- Tier 2 Participating Non-PPO (Out-of-Network) Dentists:
  Non-PPO dentists can participate on a per-claim basis by indicating on the claim form that we should pay them directly for covered services. When they do this, they enter into a contract with us for that claim and agree to accept our approved amounts as full payment for covered services. When you receive services from a Tier 2 participating non-PPO (out-of-network) dentist, you are responsible for cost sharing amounts required by your plan, as well as any charges for non-covered services.

- Nonparticipating Dentists
  When non-PPO dentists do not participate with BCBSM, we will pay you directly for covered services. Our payment will be the lesser of the amount billed or our approved amount, minus any cost sharing required by your plan. You are responsible for the entire amount charged by your dentist, which may be higher than our reimbursement.

Understanding Our Payment – Your Explanation of Benefits
After your claim is processed, we will send you an Explanation of Benefits (EOB) that provides the following information:

- The names of the dentist and the member
- A description of each service submitted on that claim
- The dates these services were provided
- The amounts the dentist charged for them and the amounts we approved, allowed and paid for them
- What you saved by going to a participating dentist
- Any deductible and coinsurance you must pay
- What you may owe

If we denied payment for any of the services that were submitted, your EOB will explain why the services were denied.

Please call Dental Customer Service if you have questions regarding payments shown on your EOB.

How to Reach Us

Call Us

If you have questions about claims or coverage, you can call Dental Customer Service at **1-888-826-8152.** Calls are answered by the interactive voice response system 24 hours a day, 7 days a week. Live Customer Service Representatives are available Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

Please have your ID card ready when you call us.

Write Us

If you have complaints or concerns, you can write to us:

Blue Cross Blue Shield of Michigan
Attn: Complaints & Grievances
P.O. Box 49
Detroit, MI 48231

Check Our Website

If you want general information about us or your dental plan, you can visit www.bcbsm.com 24/7. Log into your account to:

- Access information about your Blue Dental coverage
- Find Tier 1 PPO (in-network) dentists or Tier 2 participating non-PPO (out-of-network) dentists near you
- Review your Explanation of Benefits
- Review your claims

Section 3: Vision Services

What You Must Pay

You are required to pay the following copayment:

- In-Network Routine Eye Examination
  - Your copayment is $20

    

    After your copayment is paid, your routine eye exam is fully covered when received from an in-network provider.

  When you obtain services from an out-of-network provider, you are also responsible for paying the difference between our approved amount and the amount charged by the provider.

Vision Services We Pay For

In-Network Providers

We pay for the following vision services to detect, improve or correct vision problems:

- One routine eye exam every 12 months is covered in full after you pay your copayment
- One pair of frames or elective contact lenses every 12 months
  - Our maximum allowance for frames or elective contact lenses is $300
- One pair of standard lenses is covered in full every 12 months

Contacts that are not medically necessary are covered up to the benefit maximum.

If the lenses and frames you select are more expensive than the standard lenses and frames described above, you are responsible for the difference between what we pay and the amount charged by the provider.

An in-network provider **may bill you** when:

- You use a service that is not covered by your contract.
- We deny a claim from an in-network provider that was submitted more than 180 days after the date of service because you did not supply the needed information to the provider or to VSP.

Vision Services We Pay For (continued)

Out-of-Network Providers

We pay our approved amount for exams, lenses and frames and prescribed medically necessary contact lenses that you receive from out-of-network providers. For prescribed, non-medically necessary contact lenses, we pay our approved amount. The amount billed by an out-of-network provider may be more than our approved amount. You are responsible for paying the difference between our approved amount and the amount charged by the out-of-network provider.

You should expect to pay charges to an out-of-network provider at the time you receive the services. You should then submit a claim. If it is approved, payment will be sent to you.

We pay for the following vision services to detect, improve or correct vision problems:

- One routine eye exam every 12 months
  - Our maximum reimbursement is $45
- One pair of frames or elective contact lenses every 12 months
  - Our maximum reimbursement for frames is $70 or
  - Our maximum reimbursement for contact lenses is $105
- One pair of the following lenses every 12 months:
  - Single vision lenses – maximum reimbursement is $30
  - Bifocal lenses – maximum reimbursement is $50
  - Trifocal lenses – maximum reimbursement is $65
  - Lenticular lenses – maximum reimbursement is $100

Eye Exam

We pay for an eye exam by an ophthalmologist or optometrist. The exam must include the following:

- History
- Testing of visual acuity
- External exams of the eye
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary
- Summary of findings

Lenses

We pay for standard lenses when prescribed and dispensed by an ophthalmologist or optometrist.

- Lenses may be molded or ground, glass or plastic.
- Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.
- The lenses may be colorless or have rose tints #1 or #2 if therapeutically necessary. The provider may charge you for additional tinting other than for necessary rose tints #1 or #2.
- The lens blank of a standard lens must not exceed 60 mm in diameter. The provider may charge you for the difference in cost between standard and oversize lenses.
- If only one lens is needed, we pay half the amount we pay per pair.

We pay for the following special lenses:

- Myodisc
- Lenticular myodisc
- Lenticular aspheric myodisc
- Aphakic
- Lenticular aphakic
- Lenticular aspheric aphakic

We do not pay for aphakic lenses for aphakia (lack of natural lens). These may be covered by your hospital-medical-surgical plan.

We pay for prism, slab-off prism and special base curve lenses when medically necessary.

Frames

We pay for standard frames. If you select more expensive frames, the provider may charge you the difference between our approved amount and the provider's charge for the more expensive frames.

Contact Lenses

We pay for a contact lens suitability exam that determines whether you can wear contact lenses. The fee for this exam is included in the allowance for the contact lenses. The exam may include:

- Biomicroscopic evaluation
- Lid evaluation
- Ophthalmoscopy
- Tear test
- Pupil evaluation
- Fluorescein evaluation
- Cornea evaluation
- Lens tolerance tests

We pay for medically necessary contact lenses, less your copayment, when provided in-network. Contact lenses are considered medically necessary if:

- They are the only way to correct vision to 20/70 in the better eye or
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature.

If only one lens is needed, we pay half the amount we pay per pair.

We do not pay for cosmetic contact lenses that do not improve vision.

Exclusions

The following services are **not** covered under this certificate unless you have a rider that adds coverage for them. You are responsible for paying the charges for these services:

- We do not pay for any services that are not listed in this certificate as payable.
- We do not pay for services that are covered by Medicare.

How to Reach VSP

Call Us

For eligibility and membership questions, please call BCBSM at the phone number on the back of your ID card.

Call VSP

If you have questions about your vision coverage, call VSP at: **1-800-877-7195**.

Check VSP's Website

Visit VSP online at **www.vsp.com**.

Write VSP

Send claims for services of out-of-network providers to:

VSP
P.O. Box 495918
Cincinnati, OH 45249-5918

Section 4: Hearing Services

TruHearing Providers

Hearing care services are available in Michigan and outside of Michigan only when obtained from TruHearing Providers.

Non-TruHearing Providers

Hearing care services performed by non-TruHearing providers are not covered under this certificate.

What You Pay

Hearing Exam

- You pay $0

Hearing Aid Evaluation Test and Conformity Evaluation

- You pay $0

Hearing Aids

- Tier 1 (Basic)
  - You pay $495 per ear
- Tier 2 (Standard)
  - You pay $895 per ear
- Tier 3 (Advanced)
  - You pay $1,295 per ear
- Tier 4 (Premium)
  - You pay $1,695 per ear

Hearing Services (continued)

Hearing Care Services

The following services are covered under this certificate:

- An audiometric (hearing) examination
- A hearing aid evaluation test and a conformity evaluation
- Hearing aids, including:
  - Tier 1 – Basic
  - Tier 2 – Standard
  - Tier 3 – Advanced
  - Tier 4 – Premium

  Each hearing aid purchase includes the following:

  - Up to 3 post-purchase visits during which the TruHearing Provider will fit, adjust and educate the member on the use of the hearing aids
    - These visits must be used during within 12 months of the purchase date
  - 45-day return period
  - 3-year warranty for repairs
  - 3-year replacement warranty for loss or irreparable damage
  - 48 batteries per hearing aid (not included with purchase of rechargeable hearing aid)

This coverage includes an audiometric examination, hearing aid evaluation, conformity tests and one hearing aid per ear once every 12 months.

Exclusions

The following are not covered under this certificate:

- Services that are not listed in this certificate as covered or payable
- Services that are covered by Medicare
- Services performed by non-TruHearing providers
- Earmolds (some hearing aids styles require earmolds to function properly)
- Hearing aid accessories (including remote controls, mini mics, phone clips, TV streamers, Bluetooth accessories, etc.)
- Additional hearing aid batteries
- Additional provider visits
- Replacement warranty costs

How to Reach Us

Call Us

If you have questions about claims or coverage, you can call Customer Service at **1-844-825-0033**.

Please have your ID card ready when you call us.

Write Us

If you have complaints or concerns, you can write to us:

Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
M.C. 1620
Detroit, Michigan 48226

If you want general information about your hearing plan, you can visit https://www.bcbsm.com/medicare/ 24/7.

Section 5: General Conditions of Your Contract

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

Assignment

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

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

Changes in Your Address

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

Changes to Your Certificate

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

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.

- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Changing Your Coverage

You may sign up for other coverage if you become ineligible for coverage under this contract.

Coordination of Benefits

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

Coverage Under Previous Contracts

This certificate replaces any previous individual dental, vision or hearing certificates you had with us.

Deductibles, Copayments and Coinsurances Paid Under Other Certificates

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

Dentist of Choice

You may continue to receive services from the dentist of your choice. However, if you receive services from a non-PPO (out-of-network) dentist, you may incur additional costs.

Enforceability of Various Provisions

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

Entire Contract; Changes

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

Experimental Treatment

We do not pay for a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the member's condition. BCBSM decides if something is experimental based on one or more of the following:

- Information from the American Dental Association and other appropriate professional organizations
- Information from the Food and Drug Administration and other government agencies
- Accepted national standards of practice in the dental profession
- Scientific data such as controlled studies in peer review journals or literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies

Fraud, Waste and Abuse

We do not pay for the following:

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

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

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

Genetic Testing

We will not:

- Adjust premiums for this coverage based on genetic information related to you
- Require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you

Improper Use of Contract

If you let an ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Terminate or cancel your coverage
- Begin legal action against you
- Refuse to cover your health care services at a later date

Medicaid Eligibility

You may be eligible for Medicaid. If so, the coverage and premium under this certificate will be suspended for up to 24 months while you are eligible for Medicaid coverage. You must request this suspension within 90 days of becoming eligible for Medicaid. When we are notified, we will refund any premium you had paid for the time you were covered by Medicaid, less any amount for claims we have paid.

When you are no longer eligible for Medicaid, you must let us know within 90 days of losing Medicaid and we will renew your dental, vision and hearing contract. Your contract will be effective back to the date you lost Medicaid coverage if you pay the premium.

Notification

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

Other Coverage

In certain cases, we may have paid for dental, vision or hearing services under your certificate for which another person, insurance company or organization should have paid. In these cases:

- You grant us your right to recover our payments from them.
- You grant us a lien on all money (not to exceed the amount we paid) you or your beneficiaries recover for dental, vision or hearing costs, either through settlement, verdict or judgment.

Payment of Covered Services

The services covered under this certificate may be combined and paid according to BCBSM's payment policies.

Personal Costs

We will not pay for:

- Transportation and travel, even if recommended by a licensed practitioner, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Preapproval

Some services must be approved before they occur. If they are not preapproved, you may have to pay their entire cost. It is important to make sure that your provider gets approval before you receive services that require preapproval.

If preapproval is not obtained:

- In-state participating providers cannot bill you for the cost of their services.
- Out-of-state or nonparticipating providers may require you to pay for the cost of their services.

In addition to preapproval requirements identified within this certificate, there may be other services that require preapproval. They are subject to change. For information on preapproval, contact Customer Service.

Prior Authorization

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

Refund of Premiums

If we determine that we must refund a premium, we will refund up to a maximum of 24 months of payments.

Release of Information

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

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

Reliance on Verbal Communications

If we tell you a member is eligible for coverage, or benefits are available, this does not guarantee that claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Medical or dental necessity is verified
- Benefits are available when the claim is processed

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Services Before Coverage Begins or After Coverage Ends

We will not pay for any services, treatment, care or supplies provided:

- Before the date on which coverage under this certificate begins
- After the date on which coverage under this certificate ends

Services That Are Not Covered or Payable

We do not cover or pay for services that:

- You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate
- Are available in a hospital maintained by the state or federal government, unless payment is required by law
- Can be paid by government-sponsored health care programs, such as Medicare, for which a member is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results
- Are not listed in this certificate as being covered or payable

Subrogation: When Others Are Responsible for Illness or Injury

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

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

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

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

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

- You

You agree to:

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery.
- Not take action that may prejudice BCBSM's right of recovery.
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact BCBSM Customer Service promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.

BCBSM may:

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

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

BCBSM will:

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

  Examples where BCBSM may utilize the subrogation rule are listed below.

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

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

Subscriber Liability

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

Termination of Coverage

You must notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or

- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or

- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

If we decide to terminate your coverage under this certificate, we may notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage will end.

Time Limit for Filing Claims

We will not pay for claims for services that are not filed within 24 months from the date of service.

Time Limit for Legal Action

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

Unlicensed and Unauthorized Providers

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

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

What Laws Apply

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

Workers' Compensation

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

Section 6: Definitions

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

Abutment
Connections to natural teeth or an implant that offer retention, support and stabilization of false replacement teeth.

Accidental Injury (Dental)
An external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) or bone.

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

Amount Billed
The dollar amount that the dentist reports to BCBSM on a dental claim, less any amount that the dentist may discount, waive, rebate or has not, in good faith, attempted to collect.

Approved Amount (Dental)
The lower of the amount billed or our maximum payment level for a covered service. Coinsurances or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment. The approved amount for covered services provided by PPO (in-network) dentists may be different from the approved amount for covered services provided by non-PPO (out-of-network) dentists.

Approved Amount (Vision)
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.

Audiologist
A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

BCBSM
Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

By Report
A written explanation from the dentist that justifies the need for a procedure.

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

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

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

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

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

Contact Lenses
Contact lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the member's eye.

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 member's condition.

Copayment
The dollar amount that you must pay for a covered service. Your copayment is not altered by any audit or recovery.

Cost Sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Course of Treatment
A planned program of services for the treatment of a dental condition diagnosed by a dentist as the result of an oral examination/evaluation. A course of treatment begins on the date a dentist first provides a service to treat the dental condition.

Covered Services
A service that is identified as payable in this certificate. Such services must be dentally or medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Deductible
The amount that you must pay for covered services, under any certificate or rider, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time the claims are processed or reprocessed. Payments made toward your deductible are not altered by an audit or recovery.

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.

Dentally Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

Dentally Necessary
A service or device must be dentally necessary and appropriate according to generally accepted standards and patterns of dental practice for it to be covered by BCBSM. Dentists acting for BCBSM decide dental necessity. It is based on criteria and guidelines developed by these dentists who are acting for their respective peer provider type or specialty.

- The covered service is accepted as necessary and appropriate for the member's condition. It is not mainly for the convenience of the member or dentist.
- Covered services are subject to certain restrictions based on:
  - Policies consistent with generally accepted standards of dental practice
  - Those specific contracts that only pay for the least expensive acceptable treatment
- In the case of diagnostic testing, the results are essential to and are used in diagnosis or management of the member's condition.

When there are no established criteria, dental need will be decided by the accepted standards and practices by the dentists who are providing services for BCBSM members.

Dental Services
Services for diagnosis, prevention or treatment in connection with the care, restoration, filling, removal or replacement of teeth or the structures directly supporting the teeth.

Dentist
- **Tier 1 PPO (In-Network) Dentist**
  A dentist who has signed a contract to participate in the Preferred Provider Organization (PPO) network used by BCBSM. Tier 1 PPO (in-network) dentists agree to accept our approved amount as full payment for covered services.

- **Tier 2 Participating Non-PPO (Out-of-Network) Dentist**
  A non-PPO (out-of-network) dentist who participates with BCBSM on a per-claim basis through our Blue Par Select arrangement. Tier 2 participating non-PPO (out-of-network) dentists agree to accept our approved amount as full payment for covered services.

- **Nonparticipating Dentist**
  A non-PPO (out-of-network) dentist who does not participate with us on a per-claim basis and has not agreed to accept our approved amount as full payment for covered services. A nonparticipating dentist may bill you for the difference between what we paid you for covered services and the amount they charge.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

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

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

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

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

Experimental and Investigational Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the member's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services." BCBSM is responsible for deciding if the use of any service is experimental or investigational.

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Frames
Standard frames into which two lenses may be fitted.

Hygienist
A person who is licensed to perform specific dental procedures under the supervision of a licensed dentist. The procedures include, but are not limited to:

- Scaling
- Root planing
- Prophylaxis (teeth cleaning)
- Fluoride

In-Network Providers
Dental and vision care professionals who provide services through this PPO program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under this PPO program.

Lenses
Glass or plastic lenses prescribed by an ophthalmologist or optometrist to correct or improve vision. They are fitted into frames.

Lien
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

Medically Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

Medical Necessity or Medically Necessary
A determination by vision specialists for BCBSM, based upon criteria and guidelines developed by vision specialists for BCBSM, or, in the absence of such criteria and guidelines, based upon vision specialist review, in accordance with accepted professional standards and practices, that the service:

- Is accepted as necessary and appropriate for the member 's condition and
- Is not mainly for the convenience of the member or provider, and
- In the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the member 's condition.

For the purposes of medical necessity determinations only, vision specialist excludes opticians, optometrists and retail vision providers.

Medicare
The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Member
Any person eligible for health care services under this certificate on the date the services are rendered. The member is the "patient" when receiving services.

Network Providers
Also called “in-network providers” see the definition of “In-Network Providers.”

Nonparticipating Dentist
See the definition of “Dentist”.

Ophthalmologist
A licensed doctor of medicine or osteopathy who, within the scope of their license, performs eye exams and prescribes corrective lenses.

Optician
A specialist who fits eyeglasses and makes lenses to correct vision problems.

Optometrist
A person licensed to practice optometry in the state the service is provided.

Ordered
When the dentist has completed preparing the mouth for an inlay, onlay, crown, bridge or denture and has taken final impressions for the laboratory.

Out-of-Network Providers
Dental and vision care professionals who have not signed an agreement to provide services under this PPO program.

Patient
The subscriber who is awaiting or receiving dental, vision or hearing care.

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

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

Per Claim Participation
Available to some nonparticipating providers when they elect to accept our payment for specific covered services as payment in full.

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

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

Predetermination
A process by which a dentist submits a treatment plan to us before treatment begins. We return a copy of the proposed treatment plan to the dentist indicating covered services under the terms of your contract or available alternative treatments as determined by BCBSM.

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

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

Provider
A dentist or hygienist who provides services or supplies related to dental care.

Reimbursement
The amount BCBSM pays for a covered procedure. BCBSM’s reimbursement is based on the lesser of the amount billed or the BCBSM maximum payment level for that procedure on the date the service is provided, minus any cost sharing you are required to pay.

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

- Collect or deduct premiums from wages or other sums owed to the subscriber and
- Pay the subscriber's BCBSM bill

Rescission
The cancellation of coverage that dates back to the effective date of the member’s contract and voids coverage during this time.

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

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

Service Area
The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

Services
Care, procedures and supplies given by a dental, vision or hearing care provider to diagnose or treat conditions.

Subrogation
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your representatives.

Subscriber
The person who signed and submitted the application for coverage.

Supervision
When a dentist oversees the care of a member, is available when necessary, but is not at chair side while service and treatment are rendered.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

Tier 1 PPO (In-Network) Dentist
See the definition of "Dentist".

Tier 2 Participating Non-PPO (Out-of-Network) Dentist
See the definition of "Dentist".

TruHearing Provider
Network providers that provide hearing care services.

Vision Specialists
Licensed MDs and DOs who are board certified or board qualified in the specialty of ophthalmology, licensed optometrists, opticians and retailer vision providers.

VSP
Vision Service Plan©.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

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

Section 7: Additional Information You Need to Know

We want you to be satisfied with how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number is on the back of your ID card and in the top right-hand corner of your Explanation of Benefit Payments (EOB) statements.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for an entire service or part of a service
- Rescission of coverage
  - A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, such as a cancellation that treats a policy as void from the time of enrollment.

You may file a grievance or appeal about any adverse benefit decision or rescission within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in our review
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the Customer Service number on the back of your BCBSM ID card and ask for *a Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.
- Although we have 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to BCBSM's decision to deny, reduce or terminate or cancel your coverage.

Grievance and Appeals Process (continued)

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
  - Our failure to comply must be for more than minor violations of the internal grievance process.
    - Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

Step 1: You or your authorized representative sends us a written statement explaining why you disagree with our decision.

For dental services, mail your written grievance to:

Blue Cross Blue Shield of Michigan
Attn: Complaints & Grievances
P.O. Box 49
Detroit, MI 48231-0049

For vision services, mail your written grievance to:

VSP Appeals
P.O. Box 2350
Rancho Cordova, CA 95741

For hearing services, mail your written grievance to:

Appeals Unit
Blue Cross Blue Shield of Michigan
600 East Lafayette Blvd.
M.C. 1620
Detroit, MI 48226

Standard Internal Review Process (continued)

Step 2: We will contact you to schedule a telephone conference once we receive your grievance. During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. The written decision we give you after the conference is our final decision.

Step 3: If you disagree with our final decision, or you do not receive our decision within 60 days after we received your original grievance, you may request an external review. See below for how to request an external review.

Standard External Review Process

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

The standard external review process is as follows:

Within 127 days of the date you receive or should have received our final decision, send a written request for an external review to the Department listed below. You may mail your request and the required forms that we give you to:

Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact the Department with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

If you ask for an external review about a medical issue and the issue is found to be appropriate for external review, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and BCBSM if the Department decides to accept the group's recommendation. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Grievance and Appeals Process (continued)

Reviews of Medical Issues

Step 1: The Department will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You can give the Department additional information within seven days of requesting an external review. We must give the independent review group all of the information we considered when we made a final decision, within seven days of getting notice of your request from the Department.

Step 2: The review group will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Reviews of Nonmedical Issues

Step 1: Department's staff will review your request if it involves nonmedical issues and is appropriate for external review.

Step 2: They will recommend if the Department should uphold or reverse our decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

- If your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process to submit an expedited internal review is as follows:

Step 1: Call 1-313-225-6800 to ask for an expedited review. Your physician should also call this number to confirm that you qualify for an expedited review.

Step 2: We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

Step 3: If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review.

Grievance and Appeals Process (continued)

Expedited External Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial Services.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process is as follows:

Step 1: A request for external review form will be sent to you or your representative with our final adverse determination

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact the Department with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

Step 3: The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain services.

Your plan may require preapproval of certain services. If pre-approval is denied, you can appeal this decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the Customer Service number on the back of your BCBSM ID card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Pre-Service Review

You may make the request yourself, or your physician or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the Customer Service number on the back of your BCBSM ID and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.

Your request for a review must include:

- Your enrollee ID and group numbers, found on your BCBSM ID card
- A daytime phone number for both you and your representative
- The member's name if different from yours, and
- A statement explaining why you disagree with our decision and any additional supporting information.

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Pre-Service Review

If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible; generally, within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the Customer Service number listed on the back of your BCBSM ID card.
Pre-Service Appeals (continued)

Need More Information?

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the Customer Service number on the back of your ID card.

Other Resources to Help You

You can contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 1-877-999-6442; or
- Fax at 517-284-8837; or
- Online at https://difs.state.mi.us/Complaints/ExternalReview.aspx; or
- Mail to: Department of Insurance and Financial Services
  P.O. Box 30220
  Lansing, MI 48909-7720

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-469-2583 TTY: 711 or speak to your provider.

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

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

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

ܙܘܗܪܐ: ܐܢ ܐܡܣܠܘܢ ܒܝ ܡܫܘܬܠܦܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܫܡܫܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܒܫܘܐ ܦܪܝܐ ܩܠܘܒܢ ܕܐܠܘܟ ܐܢ ܒܥܝܬ. ܐܦ ܬܫܡܫܬܐ ܦܘܝܬܝܬܐ ܠܣܝܥܐ ܠܢܘܦܠܬܐ ܕܡܘܕܥܢܘܬܐ ܒܕܘܟܝܐ ܡܠܐܟܝܢܝܐ ܡܨܝ ܦܪܝܐ ܕܐܠܘܟ ܐܢ ܒܥܝܬ. ܡܚܝܢܘܢ ܥܠ ܡܢܝܢܐ 877-469-2583 TTY: 711 ܐܘ ܡܫܘܬܠܦܘܢ ܥܡ ܡܦܪܢܣܢܘܟܘܢ.

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

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

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

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

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

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

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

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

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

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

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

Discrimination Is Against the Law

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

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 1-877-469-2583 or, if you're 65 or older, call 1-888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 1-888-605-6461, TTY: 711
Fax: 866-559-0578
Email: CivilRights@bcbsm.com

Discrimination Is Against the Law (continued)

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

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website.

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

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