2025 Your Benefit Guide

Non-Medicare members

READY TO HELP

Blue Cross Blue Shield of Michigan

MICHIGAN

50 YEARS OF SERVICING PUBLIC SCHOOL RETIREES

Blue Cross Blue Shield of Michigan

Michigan Public School Employees' Retirement System

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Welcome to the Michigan Public School Employees' Retirement System medical plan

Blue Cross Blue Shield of Michigan and the Michigan Public School Employees' Retirement System are pleased to provide you and your family with this booklet that explains your medical benefits, effective January 1, 2025. Please take time to carefully read your benefit booklet and keep it handy for reference. This booklet replaces all previously distributed benefit documents.

In this booklet, the words "you" and "your" refer to the public school retiree and covered dependents.

Every effort has been made to ensure the accuracy of this information. However, if statements in the description differ from the applicable coverage documents, then the terms and conditions of applicable coverage documents will prevail. New benefits and benefit changes will be announced annually. If you have questions that are not answered in this book, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Blue Cross Blue Shield of Michigan administers the medical plan for the Michigan Public School Employees' Retirement System. Benefits and future modifications in benefit coverage, deductible, coinsurance and copay requirements are jointly vested by law in the Michigan Department of Technology, Management & Budget (DTMB) and the Michigan Public School Employees' Retirement Board (Retirement Board). DTMB and the Retirement Board reserve the right to change these benefits at any time in accordance with existing law.

Only you and your eligible dependents may use the benefits provided under the retirement system healthcare plans. Allowing anyone not eligible to use these benefits is illegal and subject to possible fraud investigation and termination of coverage.

Eligibility and Enrollment

The Michigan Public School Employees' Retirement System offers all pension recipients and their eligible dependents coverage in the medical plans. You're eligible to enroll at the time of your retirement or any time after that, unless you have the Personal Healthcare Fund, which only allows for enrollment at the time of retirement.

If you have the premium subsidy benefit and you're enrolling yourself, your spouse or a dependent in insurance after retirement, your coverage will begin on the first day of the sixth month after the Michigan Office of Retirement Services (ORS) receives your completed application and proofs. For example, if ORS receives your ***Insurance Enrollment/Change Request (R0452C)*** form with proofs on February 10, your coverage would begin August 1.

Coverage can begin sooner than six months if you, your spouse or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of a qualifying event. Qualifying events include adoption, birth, death, divorce, marriage, involuntary loss of coverage in a group plan (e.g., you lose your job or your employer stops offering healthcare benefits), and enrollment in Medicare Part B if your coverage was previously terminated or you were denied enrollment due to not having Part B. For retirees who do not have Medicare, coverage can begin the first of the month after ORS receives your completed application and proofs.

When you first enroll in the retirement system's medical plan, deductible amounts paid under a previous medical plan (such as your active employee plan) do not carry over to this Blue Preferred PPO medical plan.

When you become eligible for Medicare coverage

Medicare has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you're first able to, you may have to wait close to a year before your Medicare coverage becomes effective. Do not delay your enrollment in Medicare. **As soon as you or anyone else covered by your retirement system medical plan becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical) in order to remain eligible for coverage in the retirement system medical plan.** You must provide your Medicare number and Medicare Part A and Part B effective dates to ORS more than one month prior to your Medicare effective date.

If you're eligible for Medicare and fail to enroll in Part A and Part B, your retirement system medical coverage will be canceled. Your coverage can be reinstated if you enroll in Part A and Part B and notify the retirement system within one month of obtaining Medicare Part A and Part B coverage. Your coverage will begin the first of the second month after ORS receives your completed application and proofs.

Coverage for your dependents

The medical plan provides coverage to eligible dependents. An eligible dependent is:

- Your spouse. If they are an eligible public school retiree, you will be covered together on one contract.
- Your child by birth, adoption, or legal guardianship until the end of the month in which they turn 26.
- Your unmarried child by birth, adoption, or legal guardianship who is totally and permanently disabled, dependent on you for support, and unable to self-sustain employment as described below.
- Either your parent(s) or parent(s)-in-law residing in your household — one set of parents or the other, but not both.

In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. In the case of legal guardianship, official guardianship paperwork must be in place for a dependent to be eligible. Once a guardianship terminates, dependent eligibility ends.

Coverage for your non-Medicare eligible dependents is the same as yours.

Note: Stepchildren are not eligible for coverage.

Dependent children older than age 26 are not eligible for coverage on your contract unless they qualify as a disabled dependent as described in the next section. At the end of the month in which your covered dependent reaches age 26, they will be removed automatically from your medical plan coverage.

Enrolling children who do not meet the enrollment criteria, maintaining ineligible dependents on your coverage or providing false information on your enrollment application are considered healthcare fraud and are punishable by law. Further, when fraud is detected, you will be required to repay the retirement system for all medical services paid by Blue Cross Blue Shield of Michigan for the ineligible dependents.

Coverage for your disabled dependent child

To ensure coverage for your incapacitated child, you will need to provide:

- A current letter from the attending physician detailing the disability, stating the child is:
  - Totally and permanently disabled.
  - Incapable of self-sustaining employment.
- IRS Form 1040 that identifies the child as your dependent.

Coverage for a disabled dependent can begin the first of the month after ORS approves their eligibility, so it is important to provide documentation as early as possible. In some cases, we may ask for additional information to determine medical eligibility. This may delay enrollment.

Your child may be eligible for Medicare medical benefits under Social Security disability coverage. If your child is eligible, you must enroll them in Medicare in order to maintain coverage under the retirement system medical plan. Contact the Social Security Administration about enrollment. Once eligible for Medicare, your child will have coverage under the retirement system's plan for Medicare members as long as you (or your survivor, if you chose a survivor option) have coverage in the medical plan.

If your child is not enrolled in Medicare, Blue Cross' clinical staff will evaluate whether your child's condition meets the criteria for continued coverage under the retirement system. Blue Cross will ask you to submit documentation from your physician that describes the nature of your child's condition and verifies the disability. Blue Cross may also contact your child's attending physician to discuss the disability and review pertinent medical records.

Required proof(s) for coverage

You will be asked to provide photocopies of the following to ORS:

- If you're adding a spouse, a government-issued marriage certificate **or** matching addresses on your valid driver's license and your spouse's valid driver's license **and** your most recent 1040 tax form showing filing married.
- If you're enrolling your child, a government-issued birth certificate as proof of age and relationship.
- Court order to prove legal guardianship (if applicable).
- Driver's license or tax returns as proof of residence for your parent(s) or parent(s)-in-law.

These documents are referred to as *proofs*, proving eligibility for coverage.

Note: The time frame to submit enrollment request and proofs for dependents is the same as enrolling yourself in insurances.

Continuing medical coverage for your survivor

If you chose a survivor option for your pension and you have the premium subsidy benefit, your designated pension beneficiary can enroll in or continue group insurances after your death. If you chose your spouse as your survivor pension beneficiary, your eligible dependents who were covered at the time of your death will also continue to receive insurance benefits, as long as they remain eligible.

If you chose a survivor option for your pension and you have the Personal Healthcare Fund, any eligible beneficiaries and dependents who were already enrolled in insurance plans at the time of your death may continue to be enrolled in those insurance plans and they will continue to be responsible for the entire premium. If they terminate the plan at any time, they will not be able to reenroll.

If you chose no survivor option when you retired, coverage for your dependents stops at your death.

Continuing medical coverage for your dependents

When your dependents lose eligibility for coverage under the medical plan, there are options that enable them to purchase their own medical benefits: COBRA coverage or a Blue Cross Blue Shield of Michigan individual plan.

COBRA coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enables dependents who lose their group medical plan coverage (due to certain reasons) to purchase that coverage for up to 36 months. To qualify, a dependent must be enrolled in the retirement system medical plan at the time of a qualifying event that results in the loss of eligibility, which is the death of the retiree, divorce or legal separation, or loss of dependent eligibility under the requirements of the medical plan.

Qualified applicants have 60 days from the date of the qualifying event to apply to ORS for COBRA continuation of coverage. They'll receive an application and information on eligibility, monthly rates for coverage and payment information. Dependents can purchase COBRA coverage for up to 36 months.

If your dependent has been terminated from coverage and a duplicate copy of the COBRA application is needed, use the ORS miAccount Message Board to request a COBRA application.

Blue Cross Blue Shield Individual Coverage

Your enrolled dependents may purchase individual coverage through Blue Cross Blue Shield of Michigan when they no longer qualify for coverage under the retirement system. Individual coverage is an alternative to COBRA.

Your dependent can choose from various benefit levels. There will be no interruption of medical coverage if the initial bill and all subsequent bills are paid when due. Your dependent must reside in Michigan.

To ensure continuous coverage under Blue Cross Blue Shield, your dependents must apply within 30 days from the date they are no longer eligible for coverage through the retirement system. For an application form, rates and benefit information call Blue Cross Blue Shield of Michigan health plan advisors at **1-855-237-3501**. TTY users should call **711**. Information is also available at **bcbsm.com**.

Coordination of Benefits

Your medical plan contains a Coordination of Benefits (COB) provision that applies when you or your dependents are covered under more than one group medical plan. If you or your dependents are covered by another Blue Cross Blue Shield medical plan or group medical plan, your covered medical benefits will be coordinated. This means that when a service is covered by both plans, the combined payments of all group medical plans will not exceed the allowed amount for that service, after you pay any applicable deductible, coinsurance and copayment amounts.

When you enrolled in the medical plan, the application asked for information about other group medical coverage. It's important to tell the retirement system about any other medical coverage you may have because this allows us to work with the other medical plan to coordinate your benefits.

COB does not apply if you and your spouse are both Michigan public school retirees with the same group number. Insurance plans you purchase on your own, such as the AARP Plan, are not considered group medical plans.

How to complete or update your *COB Questionnaire*

You may receive a *COB Questionnaire* in the mail from Blue Cross after you receive healthcare services. The questionnaire asks if you have more than one health insurance plan and you must respond, even if the answer is no. Blue Cross can't process your claims or pay you or your healthcare providers until you respond.

You don't have to wait for Blue Cross to contact you. You can:

- Contact Blue Cross anytime you or anyone on your plan adds or drops other health insurance.
- Confirm your existing coordination of benefits information or update it when your plan renews each year; then Blue Cross won't mail you a form.

There are two ways to update your *COB Questionnaire* before receiving the form in the mail.

Online

1. Log in to your Blue Cross online member account at **bcbsm.com/mpsers** or on the mobile app.
2. Click on *My Coverage* and select *Coordination of Benefits*.
3. From there you can report any new or additional coverage that isn't listed or attest no other coverage.
4. Once complete, the *Status* box will update with the current date and details.

Phone

Call Blue Cross Customer Service at **1-800-422-9146** (TTY:**711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Determining the primary payer

Here's how to determine the primary payer:

- If the patient is the Michigan public school retiree and they also have coverage as an active employee of an employer with 20 or more employees, the active coverage has the first obligation to pay for medical costs. The retiree medical plan will pay benefits second.
- If the patient is the Michigan public school retiree or the retiree's spouse and the other group plan does not contain a COB provision, that plan will pay claims before the retirement system medical plan. The retirement system medical plan benefit payment will be reduced only to ensure all payable benefits by both plans do not exceed the total of the allowed costs.
- If the patient is the Michigan public school retiree and they are covered as a dependent on the other group plan that contains a COB provision, the retirement system medical plan will be primary. If your spouse is the patient, their group medical plan will be primary.
- If the patient is a dependent child, the primary plan is the medical plan of the parent whose birthday is earlier in the year. If the birth dates are identical, the medical plan that has covered the dependent the longest is the primary plan and will pay medical benefits first.
- Benefits for children of divorced or separated spouses are determined in the following order unless a court decree places financial responsibility on one parent:
    1. Plan of the custodial parent.
    2. Plan of the noncustodial parent.
- If the primary plan cannot be determined using the above guidelines, the medical plan covering the child the longest is primary.

Coordinating your medical plan coverage with automobile coverage

If you or an eligible dependent on your retirement system medical plan are involved in an automobile accident, payment for hospital and medical services will be coordinated between Blue Cross and your automobile insurance carrier.

In the case of an auto accident in Michigan or out of state, your medical plan has the first obligation to pay for medical care costs even if your auto policy includes personal injury protection. Blue Cross will review the claim first to pay its share of the claim. After Blue Cross reviews the claim, your auto insurance carrier will review any remaining balance for payment.

Personal injury protection coverage

Michigan drivers need to choose a level of personal injury protection (PIP) coverage appropriate for their needs and budget. In the case of an auto accident, Michigan No Fault PIP coverage pays for services that **are not covered** by your retirement system plan such as:

- Household services.
- Long-term and custodial care.
- Transportation to and from medical appointments.
- Vehicle and housing modifications.

Contact your auto insurance carrier if you have specific questions regarding PIP coverage.

Proof of qualified health coverage

When choosing your level of PIP coverage under your auto insurance policy, your auto insurance carrier may ask you to provide proof of qualified health coverage, including all individuals covered under your plan. To request a qualified health coverage letter, log in to your Blue Cross online member account or call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Filing a claim

In most instances, your provider will file your claim. However, if your provider will not file your claim, you will need to do so. If your provider will not file your claim, you must notify Blue Cross at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Discontinuing your coverage

You may voluntarily cancel your medical plan coverage or your dependent's coverage at any time by going to **michigan.gov/orsmiaccount** or by completing ORS' ***Insurance Enrollment/Change Request (R0452C)*** form. The cancellation date will be the last day of the month in which the cancellation request is received unless a future date is indicated.

If you choose to reenroll after you cancel your coverage, enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Updating your information

When to contact ORS

Notify ORS if you have any of the following changes:

- Address.
- Adoption.
- Birth.
- Death.
- Divorce.
- Email address.
- Involuntary loss of coverage in another group plan.
- Marriage.
- Medicare eligibility or enrollment.
- Name.
- Phone number.
- Other medical insurance coverage you have (such as from an employer, your spouse's employer, workers' compensation or Medicaid).
- Power of attorney (if someone else has the legal authority to act for you).

The ORS miAccount is the fastest way to access and make changes to your account. When you log in, you have secure access to change your insurance information, update your address and much more. Log in to your ORS miAccount for more information at **michigan.gov/orsmiaccount**.

You can also report membership and address changes by contacting ORS or completing and submitting the ***Insurance Enrollment/Change Request (R0452C)*** form to ORS.

ORS Customer Contact Center office hours are 8:30 a.m. to 5 p.m., Eastern time Monday through Friday.

1-800-381-5111 (TTY: **711**)
Fax: **517-284-4416**

Any changes or updates you make in your ORS miAccount or with an ORS Customer Service representative are automatically forwarded to Blue Cross. Blue Cross cannot change your records without notification from the retirement system.

To avoid misdirected communications or potential coverage problems, it is important that you contact ORS to report any of the changes noted above. This is especially important when adding or removing a dependent from your contract because you can be liable for claims paid in error.

Example: If you fail to give timely notice of divorce, you will be responsible for payments made by Blue Cross on behalf of your ex-spouse for services provided subsequent to your divorce date.

When to contact Blue Cross

You must contact Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday to notify Blue Cross of the following:

- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you're participating in a clinical research study.
- If you have other medical insurance coverage (such as from an employer, your spouse's employer, workers' compensation, or Medicaid).

How the medical plan works

When you enroll in the Blue Preferred® PPO plan

If you or your covered dependents are not yet eligible for Medicare, you'll receive medical benefits through Blue Preferred, a preferred provider organization (PPO) that offers high-level hospital, physician and other medical benefits through a network. You may choose any provider or specialist, regardless of whether they participate in the PPO network, but if you use a provider that's not part of the PPO network, you'll pay more. When you first enroll in the retirement system's medical plan, deductible amounts paid under a previous medical plan (such as your active employee plan) do not carry over to this Blue Preferred PPO medical plan.

When you become eligible for Medicare

Your medical coverage continues when you or your covered dependents become eligible for Medicare. You will enjoy the same covered services as non-Medicare members plus the additional benefits provided by Medicare. Additionally, the money you have paid toward your annual deductible while enrolled in the retirement system's non-Medicare Blue Preferred PPO plan is carried over to your retirement system's Medicare Plus Blue℠ Group PPO plan.

Most people become eligible for Medicare coverage at age 65. If you're disabled or if you have end-stage renal disease (ESRD), you may be eligible for Medicare at an earlier age.

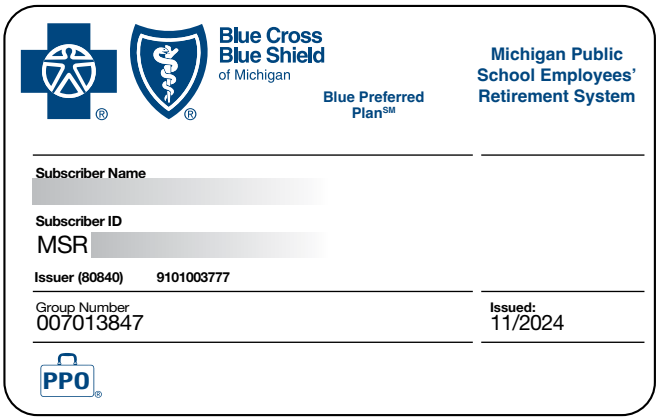
As soon as you or anyone else covered by your medical insurance becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical). You must have Medicare Part A and Part B to enroll in the retirement system medical and prescription drug programs. You must provide your Medicare number and Medicare Part A and Part B effective dates to ORS more than one month prior to your Medicare effective date.

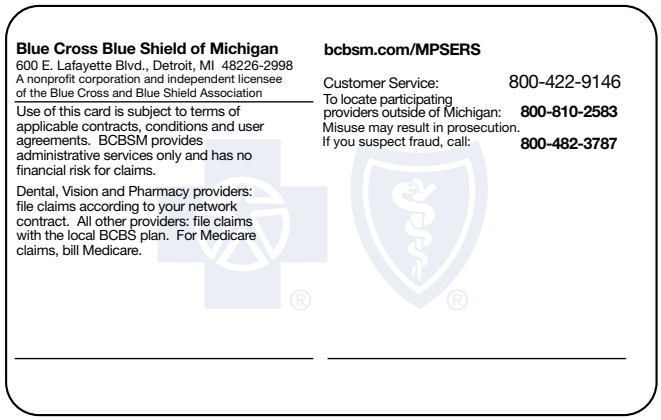
If you're eligible for Medicare and fail to enroll in Part A and Part B, your retirement system medical coverage will be canceled. Your coverage can be reinstated if you enroll in Part A and Part B and notify the retirement system within one month of obtaining Medicare Part A and Part B coverage. Your coverage will begin the first day of the second month after ORS receives your completed application and proofs.

Medicare also has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you're first able, you may have to wait close to a year before your Medicare coverage becomes effective. Do not delay your enrollment in Medicare. For more information, contact Medicare through your local Social Security office. You can also visit **medicare.gov**.

Membership ID card

As a member of the medical plan, you receive a Blue Cross Blue Shield of Michigan membership card. **Always present this and other medical plan membership cards every time you seek medical care services that are covered by the medical plan.** Your medical care providers may not know you're enrolled in another group medical plan. That's why you should always present all your medical membership cards whenever you receive services. That way, you'll be sure to get the most of your combined benefits and your medical provider will know with which plan to file the claim.





Accessing your virtual membership ID card

If you need your Blue Cross membership ID card, you can pull up your card information online or on Blue Cross Blue Shield of Michigan's mobile app. It's important that you and your covered dependents create a Blue Cross online member account to see the ID card information anytime, anywhere. To access your virtual ID card, log in on Blue Cross Blue Shield of Michigan's mobile app or at **bcbsm.com/mpsers** and select *ID Cards*.

If you haven't registered for Blue Cross Blue Shield of Michigan's online member account, click *Register Now* and follow the instructions to create your account.

Lost or stolen membership ID card and ordering a replacement ID card

If your membership card is lost or stolen, immediately call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday to report the loss. There's no charge for a replacement card, and you can still receive services until your new card arrives.

You can save time by ordering your replacement membership ID card online.

1. Log in to your account at **bcbsm.com/mpsers** or Blue Cross Blue Shield of Michigan's mobile app and click *ID Cards*.
2. Select *Order* below the card image.
3. Make sure your address is correct and select *Confirm order*.

Things to be aware of throughout the year

LivingWell program

LivingWell is a program that helps you track your health, identify areas for improvement and work on an action plan with your primary care provider.

You have an opportunity to earn up to a $200 annual deductible credit by participating fully in the LivingWell program.

Each year you will receive a LivingWell questionnaire from Blue Cross. To participate in the LivingWell program, complete the questionnaire, identify your primary care provider in the space provided on the form and visit your primary care provider for an annual routine physical. By completing these three steps, you'll receive a $150 deductible credit. The physical exam is covered by your medical plan at no cost to you in network. Your plan covers in-network standard, routine laboratory tests at no cost to you when done in conjunction with an annual routine physical. If you have questions about which tests are covered at 100% and which have out-of-pocket costs, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Select a patient-centered medical home (PCMH) doctor as your primary care provider to earn an additional $50 deductible credit.

In a patient-centered medical home, one doctor leads a care team that focuses on keeping you healthy instead of just treating you when you're sick. It's a partnership between you and your doctor. Here are three reasons to consider choosing a PCMH:

1. **Your PCMH health team revolves around you.** When you choose a PCMH doctor, your doctor leads a team of medical care professionals committed to improving your health. Your PCMH health team may consist of your primary care provider, nurses, specialty doctors, pharmacists, a nutritionist, therapist, care coordinators and others depending on your needs.
2. **Your care team works together to help you manage your health.** Your PCMH doctor tracks your care and coordinates your care between doctors and healthcare settings. If you need to see a specialist, your PCMH doctor will help you find the right one and coordinate your visit. Because all your tests and treatments by other doctors are tracked to your primary care provider, you have a centralized home for your medical history. You won't have to re-explain every symptom and test result each time you visit your doctor. Your doctor also uses e-prescribing (or an electronic prescription system) to alert your pharmacist of any possible drug interactions and help eliminate errors.
3. **You'll have more access to your medical team.** PCMH practices offer extended office hours, making it easier to get same-day appointments when you have a health issue. Your PCMH also provides 24-hour access to your care team. If you have a medical question in the middle of the night or on a weekend, you can call your PCMH and possibly avoid a trip to the emergency room.

PCMH practices aim to prevent problems from occurring and put control of your health where it belongs — with you and your care team.

Find a PCMH practice. To find a patient-centered medical home doctor, use the *Find a Doctor* tool at **bcbsm.com/mpsers** or on Blue Cross Blue Shield of Michigan's mobile app.

If you're a new member, you'll receive information about the LivingWell program in the mail from Blue Cross in the fall.

Best of Health newsletter

The *Best of Health* newsletter aims to help you understand your medical coverage, improve nutrition and fitness, manage chronic conditions and more. Visit **bcbsm.com/mpsers** and select *For Members* and click on *View all issues* to view the latest issue or sign up to receive your newsletter electronically. Members who provided an email address to the ORS will automatically receive the quarterly newsletter electronically. The newsletter is released at the end of March, June, September and December of each year.

Plan updates

Plan updates are announced in the *Best of Health* newsletter and annual retiree healthcare plan seminar.

Taking care of your health

Blue Cross Well-Being℠

Whether you're looking for ways to improve your lifestyle or manage a chronic illness like asthma or high blood pressure, Blue Cross Well-Being has the support system you need. You can get to Blue Cross Well-Being by logging in to your account at **bcbsm.com/mpsers**. Once you're logged in, you can:

- Research topics specific to men, women and mature adults.
- Use calculators to determine healthy weight, calorie burn rate, target heart rate and much more.
- Take quizzes on a number of health topics.
- Watch videos, listen to podcasts and use other online tools to learn about various health topics.

Blue Cross Well-Being also provides:

24-Hour Nurse Line

Supported by board-certified physicians, Blue Cross nurses are available — day or night — from the comfort of your home or anywhere in the United States to help you decide where to go for care or provide you with recommended treatment options for minor illnesses.

To speak to a registered nurse or order health education brochures, call Blue Cross Well-Being, toll free 24 hours a day, seven days a week at **1-855-624-5214**. TTY users, call **711**.

Health assessment

The health assessment provides you with a picture of your current health and your health risks. In an easy-to-read format, the assessment asks you questions designed to evaluate your health risks and provides steps which you can take to improve those risks.

NEW! Online well-being resources

Blue Cross has partnered with Personify Health to provide a platform designed to empower you to make lasting changes toward a healthy lifestyle. Personify Health is available to you and your covered family members. To get started, log in to your Blue Cross online member account, then click on the *Programs & Services* tab. From there, select *Blue Cross Well-Being* under *Quick Links*.

NEW! Tobacco Coaching

The Tobacco Cessation Coaching program offers personalized support to help you stop smoking, vaping or using nicotine. The same coach stays with you throughout your journey to quit. You can connect with your coach by phone, app or email. To get started, log in to your Blue Cross online member account, then click on the *Programs & Services* tab. From there, select *Blue Cross Well-Being* under *Quick Links*.

Blue Cross Coordinated Care Advocate℠ program

The Blue Cross Coordinated Care Advocate program allows you to get help, answers and clarity with just about anything related to your healthcare.

Care advocates are registered nurses ready to help you. Whether you want advice about an upcoming surgery, are seeking information on a specific condition or need guidance in selecting a primary care provider, care advocates:

- Make the healthcare process easier.
- Guide and support you in making decisions.
- Give you advice to get the best care available for your specific needs.
- Can assist with scheduling healthcare appointments.

Care advocates are like having a nurse in the family to turn to with your medical concerns. They'll take the right steps to make better whole body healthcare happen for you.

To contact a care advocate, call **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. After your first contact, you can use the Blue Cross Coordinated Care℠ app to stay connected.

Blue365®

Through Blue365, a Blue Cross member discount program, you have access to exclusive discounts on national and local healthy products and services, including gym memberships, fitness products, healthy eating programs and more. The Blue365 program offers savings and special discounts, making it easier and less expensive to get the balanced lifestyle you deserve in these categories:

- **Fitness and well-being** — Gym memberships, fitness gear, fitness wearable devices and health magazines.
- **Nutrition** — Meal delivery kits and weight-loss programs.
- **Lifestyle** — Landscaping materials, pet supplies and multivitamins.
- **Travel** — Hotel reservations, car rentals and vacation activities.

Log in to your account at **bcbsm.com/mpsers** or Blue Cross Blue Shield of Michigan's mobile app. Once you're logged in, select *Blue365 Rewards & Discounts* from the *Programs & Services* menu. Scroll down to *Blue365 Member Discounts* and tap or click the button to link to the Blue365 site.

Visit the Blue Cross website

Information is available online 24 hours a day, seven days a week at **bcbsm.com/mpsers**. From **bcbsm.com/mpsers** you can log in to your online Blue Cross member account from your computer or via the mobile version from your smartphone for the following:

- **Claim information** — View claim information and out-of-pocket costs.
- **Cost comparison tool** — Compare cost estimates for healthcare services.
- **Provider search** — Search for providers by doctor's name, specialty, network; view side by side comparisons of doctors, including patient reviews.

Visit **bcbsm.com/mpsers** to view plan documents, such as the *Summary of Benefits* and *Best of Health* newsletters.

To help you stay organized and avoid the clutter, you can sign up to receive electronic plan documents.

Going paperless is easy. Here's how:

1. Go to **bcbsm.com/mpsers**. Click *Log in*. Enter your username and password. If you haven't registered, click *Register Now* and follow the instructions to create your account.
2. Click on your name listed in the top right corner.
3. Click on *Paperless Options* from the list.
4. Under *Paperless Options*, click on *Paperless* to select paperless delivery of the documents you want to get online.

Blue Cross webcasts and webinars

Informative webcasts and webinars can be found under *For Members* at **bcbsm.com/mpsers**, including:

- Blue Cross Virtual Well-Being.
- The Basics of Medicare.
- Fall Retiree Healthcare Plan Seminar.
- Patient-Centered Medical Home Program.

Out-of-Pocket Costs

The medical plan is designed to cover most costs associated with your medical care. You pay a minimal percentage of the cost of covered benefits in addition to any monthly premium deducted from your pension payment. The medical plan features out-of-pocket costs that apply to all members:

- Annual deductible.
- Coinsurance (up to the coinsurance maximum).
- Copay.
- Additional costs for using out-of-network providers.
- Additional costs for using providers that don't participate with Blue Cross.

Annual deductible

Each calendar year, you're required to meet a deductible before the plan will pay benefits. Your current deductible is **$1,000** per non-Medicare member. Your medical plan deductible renews on January 1 of each year, regardless of whether you paid your full deductible for the prior year.

You can lower your annual deductible and receive up to a $200 credit if you fully participate in the LivingWell program. Refer to the *LivingWell program* section of this booklet for more information.

Deductible amounts paid under a different medical plan not administered by your retirement system do not carry over to this Blue Preferred® PPO medical plan. In cases where an enrolled dependent loses eligibility and obtains individual coverage, deductible amounts paid for that dependent under this medical plan do not carry over to the new coverage. If you chose a survivor option at retirement, amounts paid toward your deductible at the time of your death will not be counted toward your surviving spouse and any other dependents' deductible. Your survivors will be credited only for deductible amounts paid for their own covered services.

The amount applied to your deductible is based on the amount approved by Blue Cross, not the provider's charge.

Coinsurance

A coinsurance requires you to pay a percentage of the cost of certain medical care services. Your coinsurance is different from your deductible and is applied to services after you have met your deductible. The amount of your coinsurance is based on the amount approved by Blue Cross for covered services. If the provider's charge is less than the amount approved by Blue Cross, then your coinsurance is based on the provider's charge. For most covered services, the medical plan pays 90% of the approved amount, and your coinsurance is 10%.

Copayment (copay)

A copayment (copay) is a flat dollar amount that you pay when you receive certain medical services. Copays are not included in the annual coinsurance maximum.

Additional costs for using out-of-network providers

With a few exceptions, you pay an additional 20% of the amount approved by Blue Cross if you use providers outside the Blue Preferred PPO network. This means that you will pay 30% of the amount approved by Blue Cross for most services received outside the Blue Preferred PPO network: 10% coinsurance plus the additional 20% for using a provider not part of the Blue Preferred PPO network. If your network provider refers you to a provider not part of the Blue Preferred PPO network — such as a specialist — the additional 20% is waived and you pay the regular coinsurance for the service.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305**, (TTY: **711**) Monday through Friday 8 a.m. to 8 p.m. and follow the instructions you're given.

IMPORTANT: You can save money when you use in-network providers because your 10% coinsurance is based on the amount approved by Blue Cross. In-network providers agree to accept a lower approved amount for the services they provide, which means you pay less out-of-pocket.

Additional costs for using providers that do not participate with Blue Cross

Providers that do not participate with Blue Cross Blue Shield do not have an agreement with Blue Cross Blue Shield plans to accept the amounts approved by Blue Cross. When you use providers that do not participate with Blue Cross Blue Shield, in addition to your deductible, copay and coinsurance, you're responsible for paying the difference between the amount approved by Blue Cross and the provider's charge.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. and follow the instructions you're given.

Annual coinsurance maximum

The medical plan limits the amount you will pay each year in coinsurance for medical services when using in-network providers. Once coinsurance payments total **$900** per member, all covered services that were paid at 90% will be paid at 100% of the approved amount for the rest of the calendar year except for emergency room and urgent care visits. Once your coinsurance payments total $900 per member, you only pay the emergency room visits, urgent care visits and routine hearing care copays for the rest of the calendar year.

You may not use the following charges to meet your coinsurance maximum:

- Copays.
- Deductible amounts.
- Additional costs for using out-of-network providers.
- Additional costs for using providers that do not participate with Blue Cross.
- Charges for non-covered services.

How your annual deductible and coinsurance are applied

The examples below show how a member's costs are calculated for four different claims. Because the member is enrolled in the LivingWell program, the member has an $800 deductible.

	Total cost (allowed amount the plan has approved)	Amount you owe toward your annual deductible		Amount you owe in coinsurance		Your share of cost	Retirement system pays the remaining balance
Claim example 1							
Before you've paid any deductible	$1,500	$800	+	$70 ($1,500 - $800 = $700; 10% of $700 = $70)	=	$870	$630
Claim example 2							
After you've paid $500 toward the deductible	$700	$300	+	$40 ($700 - $300 = $400; 10% of $400 = $40)	=	$340	$360
Claim example 3							
After you've paid the annual deductible	$2,000	$0	+	$200 ($2,000 - $0 = $2,000; 10% of $2,000 = $200)	=	$200	$1,800
Claim example 4							
After you've paid the annual deductible and coinsurance maximum	$1,650	$0	+	$0	=	$0	$1,650

Note: *Retirees who do not fully participate in the LivingWell program have a higher annual deductible.*

Benefit dollar maximum

The medical plan covers organ and tissue transplants services. Travel and lodging to and from the designated facility for the transplant surgery is covered, up to a $10,000 maximum. Reasonable and necessary costs are covered for the patient and one companion (two companions if the patient is under age 18 or the transplant involves a living donor related to the patient). Refer to the *Transplants* section of this booklet for more information.

Selecting your providers and using the Blue Preferred® PPO network

Select a primary care provider who's right for you

If you don't already have a primary care provider, consider choosing one to help you manage and coordinate all your medical care needs. This physician will get to know your medical history and lifestyle so that they will be in the best position to perform your regular checkups, refer you to specialists or coordinate any necessary hospital care.

Having a good relationship with your primary care provider is important. The doctor-patient relationship and the advantages that go along with it are at the core of the PCMH concept. Refer to the *LivingWell program* section in this booklet for more information about PCMH and how you can lower your annual deductible by using a PCMH doctor.

Your medical plan offers the maximum benefit with the lowest out-of-pocket costs when you use Blue Preferred PPO network providers in Michigan and BlueCard® PPO providers outside Michigan. Many providers that are not part of the PPO network may participate with Blue Cross Blue Shield plans and you may still lower your out-of-pocket costs by using these providers.

Using a network provider

The medical plan offers these provider networks for retirees and their dependents:

- **Blue Preferred is a preferred provider organization (PPO) network** of doctors, hospitals and other medical care specialists in Michigan. Outside Michigan, you have access to network providers through the BlueCard PPO program. As part of the national Blue Cross Blue Shield Association of plans, you'll find Blue Preferred PPO providers in every state. Using BlueCard will minimize your cost and, in most cases, eliminate the need to file a claim. To find a PCMH provider in the Blue Preferred PPO network, use the *Find a Doctor* tool at **bcbsm.com/mpsers**. Refer to the *LivingWell program* section for more information on PCMH and how selecting a PCMH doctor as your primary care provider can lower your out-of-pocket cost.
- **Quest Diagnostics network** of independent laboratories in Michigan (independent laboratories are not affiliated with a hospital).
- **Your routine hearing care benefits** are exclusively available through a national network of TruHearing providers. Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

Referrals to providers

For some conditions, you may need to see a specialist or another physician. Your network physician can help you find an appropriate provider. You also may select a specialist or other physician on your own.

In some situations, your Blue Preferred PPO physician may refer you to a provider that is not in the network. Your physician will complete a referral form for you to bring to your out-of-network provider. When this happens, you will not have to pay the additional 20% of the amount approved by Blue Cross normally charged for using out-of-network providers.

If the out-of-network provider you've been referred to participates with Blue Cross, you're only responsible for your 10% coinsurance and deductible. If the out-of-network provider doesn't participate with Blue Cross, you're responsible for the difference between the provider's charge and the amount approved by Blue Cross in addition to your 10% coinsurance and deductible.

	In-network provider	Out-of-network provider that participates with Blue Cross	Provider that does not participate with Blue Cross
Your provider	• Member of the Blue Preferred PPO network. • Blue Cross selects for quality of care, ability to provide cost-effective services and ability to meet Blue Preferred PPO standards.	• Not a member of the Blue Preferred PPO network but participates in other Blue Cross plans. • Blue Cross selects for quality of care, ability to provide cost-effective services.	• No affiliation with Blue Cross Blue Shield. • No quality screening by Blue Cross Blue Shield.
Your cost	• Lowest out-of-pocket cost. • Coinsurance or copay on most services. • Deductible.	• Low out-of-pocket cost. • Coinsurance or copay on most services. • Deductible. • Additional cost for using provider outside the Blue Preferred PPO network.	• Higher out-of-pocket cost • Coinsurance or copay on most services. • Deductible. • Additional cost for using provider outside the Blue Preferred PPO network. • You pay cost difference between provider charge and the amount approved by Blue Cross.
Claim filing	• Provider submits claim for you. • Blue Cross pays provider directly.	• Provider submits claim for you. • Blue Cross pays provider directly.	• You file claims for covered services. • Payment from Blue Cross Blue Shield of Michigan is made to you; it's your responsibility to pay the provider.

Locating network providers in Michigan

There are three ways to locate a Blue Preferred PPO provider, including PCMH-designated practices:

- If you already have a physician, call and ask if they are a Blue Preferred PPO physician.
- Visit Blue Cross Blue Shield of Michigan's website at **bcbsm.com/mpsers** or mobile app. The online directory is easy to use and is frequently updated.
- Call Blue Cross Customer Service at **1-800-810-2583** for help in locating network and participating providers in your area. TTY users should call **711**.

If you select a network physician and later wish to change physicians, there is no waiting period or paperwork. Just select another physician in the Blue Preferred PPO network and make your appointment. You don't have to notify Blue Cross.

You save when you use network providers
The Blue Preferred PPO plan offers choice when it comes to selecting providers, but you pay more when you use out-of-network providers. Blue Cross carefully selects providers for the quality of care they provide and ability to provide cost-effective medical care services. That means you save when you use Blue Preferred PPO providers.

For routine hearing exams and hearing aids, you must call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

Laboratory network in Michigan

Quest Diagnostics provides laboratory services in Michigan. Most of the time, you will not need to do anything special to use your laboratory network. That's because whenever you receive lab tests in a PPO network doctor's office, your doctor is responsible for sending them to Quest Diagnostics for processing.

If you need to go directly to a laboratory for tests, make sure you select one of the Quest Diagnostics laboratories to minimize your out-of-pocket costs.

To locate the nearest Quest lab, call Quest Diagnostics Customer Service at **1-866-697-8378** or visit **questdiagnostics.com**. TTY users should call **711**.

Locating network providers outside Michigan

If you live or travel outside Michigan, the medical plan offers the BlueCard® PPO network. Just visit **bcbs.com** or call **1-888-630-BLUE (2583)** and representatives will give you names, addresses and phone numbers of quality BlueCard® PPO providers in your area. TTY users should call **711**. If you're experiencing a medical emergency, call 911 or go to the nearest emergency room.

For routine hearing exams and hearing aids, you must call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

Laboratory services outside Michigan

The Quest Diagnostics network is located only in Michigan. If you're living or traveling outside Michigan and need laboratory services, you'll save money by using a lab that participates with the local Blue Cross Blue Shield plan.

Virtual visits

With Virtual Care by Teladoc Health®, you and everyone on your medical plan can get virtual medical and mental healthcare from a smartphone, tablet or computer.

Medical care
Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Mental healthcare
Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression. Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability. Therapy visits are scheduled for 45 minutes. Psychiatry visits are 30 to 40 minutes for the initial visit; follow-up visits are 15 minutes.

Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app. Family members ages 18 and older will need to create their own Virtual Care account. If you have questions or need help with your Virtual Care account or an online visit, call 1**-855-838-6628** (TTY: **711**). Help is available 24 hours a day, seven days a week.

Remember to coordinate all your care with your primary care provider and follow up with them after receiving care.

Your primary care provider may offer virtual visits. Talk to your provider about the services he or she offers. Refer to the *Doctor visits, virtual care visits and other medical services* section of this booklet for additional information.

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

Locating network providers outside the United States

For non–emergency inpatient medical care outside of the United States, you must call Blue Cross Blue Shield Global® Core to arrange access to a Blue Cross Blue Shield Global Core hospital. Call **1-800-810-BLUE (2583)** and select international option or call collect at **1-804-673-1177** if you're calling outside the United States. TTY users should call **711**. If your hospitalization is arranged through Blue Cross Blue Shield Global Core, the hospital will file the claim for you. You will need to pay the hospital the coinsurance and deductible. For a current list of these hospitals, visit the Blue Cross Blue Shield Global Core website at **bcbsglobalcore.com** or download the Blue Cross Blue Shield Global Core mobile app.

For outpatient and doctor care or inpatient care not arranged through Blue Cross Blue Shield Global Core, you will need to pay the provider and submit a claim form with original bills to Blue Cross Blue Shield of Michigan.

Your covered hospital and medical benefits and cost share is the same when you travel to a foreign country as if the services were rendered in the United States. For covered services performed abroad, the medical plan will pay the approved amount at the rate of exchange in effect on the date of service. You're responsible for costs that exceed Blue Cross' approved amount plus your coinsurance, copay and deductible.

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

For routine hearing exams and hearing aids, you must call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

Blue Distinction Centers®

Blue Distinction Centers are hospitals that meet high quality standards for specialty care. Blue Distinction Centers+® are hospitals that meet the program's high quality and cost-efficiency standards for specialty care. Expert physicians and medical organizations help develop the standards for this program for Blue Cross Blue Shield of Michigan. Members can find hospitals that deliver high quality, cost-efficient care for:

- Bariatric surgery.
- Cardiac care.
- Complex and rare cancers.
- Knee and hip replacement.
- Spine surgery.
- Transplants.

If you ever need the services described above, Blue Cross strongly recommends taking advantage of these centers because they've achieved better results: low readmission rates and, most critical, fewer medical complications and deaths. For information about the Blue Distinction Centers and a current list of hospitals, visit **bcbsm.com** or call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Medical providers not included in the Blue Preferred PPO network

Prior to obtaining services from the providers below, you must confirm that the facility or provider is approved. If not, you may be responsible for all or a percentage of the charges. For assistance, call Blue Cross Customer Service at **1-800-422-9146** (TTY:**711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Types of facilities and providers that are not part of the Blue Preferred network include:

- Ambulance.
- Hearing aid providers — Your routine hearing care benefits are available through a national network of TruHearing providers.
- Home health agencies.
- Home dialysis providers.
- Hospice.
- Independent medical suppliers.
- Outpatient psychiatric and substance use disorder facilities.
- Religious non-medical healthcare institutions.
- Skilled nursing facilities.
- Surgery center.

Your medical benefits

This chapter describes the medical benefits provided under the medical plan. If your only medical coverage is through the medical plan — that is, if you're not yet eligible for Medicare or covered by another group medical plan — then your benefits will be paid as outlined here. If you have other medical coverage, please also see the *Coordination of Benefits* section in this booklet.

You can log in to the secured online member account at **bcbsm.com/mpsers** to view claim information and track out-of-pocket costs.

Your medical plan is designed to pay for medical care when you need it. **Unless otherwise specified, a service must be medically necessary to be covered by the medical plan.** If the service is not medically necessary, you'll be responsible for all of the cost. For a full explanation of medical necessity for hospital and physician services, see "Medical necessity" in the *Glossary of medical care terms* section of this booklet.

Federal and state laws protect the privacy of your medical records and personal health information. Your personal health information is protected as required by these laws.

Hospital benefits

Inpatient hospital care

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan provides unlimited days for inpatient hospital care for the diagnosis and treatment of medical, behavioral and mental health conditions. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Hospital care includes the care you get in acute care hospitals, inpatient rehabilitation facilities and long-term care hospitals.

Covered services include:

- Semiprivate room.
- Meals, including special diets.
- Physician services.
- Regular nursing services.
- Cost of special care units (such as intensive care or coronary care units).
- Operating and recovery room costs.
- Drugs and medications.
- Lab tests.
- X-rays, CAT scans, MRIs, PET scans and other radiology services*.
- Anesthesia, including administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service*.

- Blood used for each condition or diagnosis, including storage for blood before surgery.
- Diagnostic tests, such as EEGs, EKGs, ECGs and EMGs*.
- Chemotherapy and radiation therapy.
- Customary, standard and medically-accepted artificial prosthetic devices when permanently implanted internally, such as heart valves and hip joints.
- Oxygen and other gas therapy.
- Necessary surgical and medical supplies.
- Use of appliances and equipment, such as wheelchairs.
- Physical, occupational and speech language therapy for the treatment of the condition for which you're hospitalized.
- Routine nursery care of a newborn during the mother's eligible stay.
- Behavioral health, mental health and substance use disorder services.

**The additional 20% of the amount approved by Blue Cross does not apply to physicians outside the PPO network if the hospital is in the PPO network.*

Bariatric surgery and certain transplants are only covered if certain medical criteria are met and the service is performed in a Blue Distinction Center. For a current list of hospitals, visit **bcbsm.com** or call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. Refer to the *Transplants* section for more information about transplants that must be performed in a Blue Distinction Center.

Are you an inpatient?
Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you haven't been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests or X-rays.

Inpatient physician care

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your hospital benefit covers:

- **Inpatient physician visits** — You're covered for inpatient medical care from a physician, including care for general medical, behavioral and mental health conditions.
- **Inpatient care from a specialist** — You're covered when you're being treated by more than one physician only if the doctors have different specialties and you're being treated for more than one medical condition.
- **Inpatient physician consultations** — In complicated situations, the physician in charge of your case may consult another physician for assistance or advice in making a diagnosis or providing treatment. Patient consultations are covered when medically necessary and requested by your attending physician.

Outpatient hospital care

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

The services listed under inpatient hospital benefits are also covered when performed in the outpatient department of a hospital. Refer to *Emergency Services* for information on cost share for emergency room care.

Partial hospitalization is covered for active psychiatric treatment provided in a hospital outpatient setting or by a community behavioral and mental health center. Partial hospitalization is a structured program that is more intense than the care received in a doctor's or therapist's office and is an alternative to inpatient hospitalization.

Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.

Emergency services

Emergency room care

What you pay
In and Outside PPO network
10% coinsurance, after the annual deductible. $140 copay per visit once the annual coinsurance maximum is met. The $140 copay is waived if you're admitted to the hospital within 72 hours.

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers medical emergency care when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

Examples of covered emergency services include:

- Severe chest pain.
- Loss of consciousness.
- Convulsions.
- Broken bones.
- Cuts requiring prompt medical treatment.
- Frostbite.

Other services that may be provided in treating the emergency (for example, physician services, laboratory, X-ray, etc.) are discussed elsewhere in this booklet.

Urgently needed care

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible. $65 copay per visit once the annual coinsurance maximum is met.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. $65 copay per visit once the annual coinsurance maximum is met. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

An urgently needed service is a non-emergency situation requiring immediate medical care. The urgent condition could, for example, be an unforeseen flare-up of a known condition that you have.

What type of treatment should you get?
Is it a minor illness, or something more serious? Should you go to the emergency room or wait for an appointment with your primary care provider? Or can you take care of yourself at home? The Blue Cross Well-Being 24-Hour Nurse Line may help you. This 24-hour, seven day a week nurse hotline is available free to all enrolled members. You can speak directly with a registered nurse by calling the 24-Hour Nurse Line at **1-855-624-5214**. *TTY users, call* **711**. *Refer to the Blue Cross Well-Being section for more information.*

Ambulance services

What you pay	
Provider approved by Blue Cross	**Non-approved provider**
10% coinsurance, after the annual deductible.	10% coinsurance, after the annual deductible plus the difference between the provider's charge and the amount approved by Blue Cross.

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers ground ambulance transportation when you need to be transported to a hospital or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. The medical plan may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide. In some cases, the medical plan may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. The medical plan will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need. Ambulance services without transportation are also covered.

The Blue Preferred® PPO network does not include ambulance providers, but the medical plan will cover this service if the provider is approved by Blue Cross.

Surgical services

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

Surgical procedures are covered when required for the diagnosis and treatment of a disease or injury and performed in an approved location, such as a hospital, physician's office or ambulatory surgical center.

Services received in an ambulatory surgical center are payable only when performed in a center approved by Blue Cross. This care generally includes elective surgery that does not require the use of hospital facilities and support systems, but is not routinely performed in an office setting.

In addition to general surgery, the following surgeries and surgical services are covered:

- **Dental surgery** to remove impacted teeth or to perform multiple extractions is covered only when you're hospitalized for the surgery because of a concurrent medical condition, such as a heart condition. The inpatient admission for the dental surgery must be considered medically necessary to safeguard your life.
- **Cosmetic surgery** is limited to the correction of deformities present at birth, conditions caused by accidental injuries and deformities resulting from cancer surgery, such as breast reconstruction following a mastectomy. Your doctor must pre-authorize the procedure and your benefits are subject to specific medical criteria. Surgery primarily for improving your appearance is not covered.
- **Anesthesia** — Covered services include drugs or gases and their administration when medically necessary for a covered service and when given by a physician other than the operating surgeon or an assistant. Anesthesia provided by a Certified Registered Nurse Anesthetist under the direction of an anesthesiologist is also covered.
- **Technical surgical assistance** — Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring the assistance must be an approved major-surgical procedure.
- **Multiple surgeries** — Two or more surgical procedures performed during the same operative session are subject to payment limitations.

Doctor visits, virtual care visits and other medical services

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your medical plan covers visits to a physician for the examination, diagnosis and treatment of general medical conditions. Services such as medical care, including urgent medical care, consultations, injections and medications are payable in the physician's office, clinic or in your home.

In addition to physicians, the medical plan also covers medically appropriate services provided by other qualified medical care providers, such as physician assistants, nurse practitioners, social workers, physical therapists and psychologists.

Save money on your doctor visits
You can limit your out-of-pocket costs for doctor visits by using network providers. Your coinsurance will be less and you won't have to pay additional charges for covered services. In most cases, you won't have to bother with paperwork. Network providers will file your claim for you.

Allergy treatment

Covered services include tests to help arrive at a diagnosis.

Cardiac rehabilitation

The medical plan covers comprehensive programs that include exercise, education and counseling for patients who meet these conditions:

- A heart attack in the last 12 months.
- Coronary artery bypass surgery.
- Current stable angina pectoris (chest pain).
- A heart valve repair or replacement.
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open).
- A heart or heart-lung transplant.

The medical plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting.

Chemotherapy services

The medical plan covers chemotherapy, including administration of therapy, doctor services and the cost of drugs, except when the treatment or drugs are considered experimental or investigative. Drugs covered under the retirement system's prescription drug plan are not covered under the Blue Preferred® PPO Plan.

Chiropractic services

Chiropractic benefits are limited to spinal X-rays and spinal manipulations for diagnoses related to the spine (subluxation of the spine). The medical plan covers up to 26 spinal manipulations per calendar year.

Dental services

The medical plan doesn't cover most dental care, dental procedures, or supplies, such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. You have coverage for certain dental services that you get when you're in a hospital. You also have coverage for services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face. The injury must have occurred after the effective date of your coverage. Services must be performed by a physician or dentist. The medical plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.

Infusion therapy

Infusion therapy is 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. The medical plan covers infusion therapy in the home, at a doctor's office and at an ambulatory infusion center.

The drugs used in infusion therapy must be approved by Blue Cross. Home infusion therapy is covered when it is:

- Prescribed by a physician within their scope of practice to:
  - Manage an incurable or chronic condition.
  - Treat a condition that requires acute care if it can be managed safely at home.
- Certified by the physician as medically necessary for the treatment of the condition.
- Appropriate for use in the patient's home.
- Medical IV therapy, injectable therapy or total parenteral nutrition therapy.

Home infusion therapy coverage includes:

- Nursing visits needed to:
  - Administer home infusion therapy or parenteral nutrition.
  - Instruct patient or caregivers on infusion administration techniques.
  - Provide IV access care (catheter care).
- Durable medical equipment, medical supplies and solutions needed for home infusion therapy or parenteral nutrition.

Medication

The medical plan covers a limited number of prescription drugs such as injections you get in a doctor's office, certain oral anti-cancer drugs and drugs used with some types of durable medical equipment (such as a nebulizer or external infusion pump). Self-administered drugs (drugs you would normally take on your own) are not covered. Certain drugs require prior authorization.

Occupational therapy

The medical plan covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other healthcare provider certifies you need it. These services are covered only when the services are specific, safe, provided for rehabilitation and an effective treatment for your condition. To qualify for coverage, therapy must address a condition that can be improved within a reasonable and generally predictable time frame (typically around six months), or it must aim to optimize your developmental potential or maintain your current level of functioning.

Occupational therapy services can be performed in a freestanding facility or the office. Before receiving treatment, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday for information on approved facilities, procedures and diagnoses.

Office visits

The medical plan covers primary and specialist visits to a physician for the examination, diagnosis and treatment of general medical conditions. Refer to the *Preventive Services* section of this booklet for routine physical exam information.

Pain management

Pain management is an integral part of a complete disease treatment plan. You have coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases.

Physical therapy

The medical plan covers the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness or injury or following surgery when your doctor or other medical care provider certifies your need for it. These services are covered only when the services are specific, safe, provided for rehabilitation and an effective treatment for your condition. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:

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

To qualify for coverage, therapy must address a condition that can be improved within a reasonable and generally predictable time frame (typically around six months), or it must aim to optimize your developmental potential or maintain your current level of functioning.

Physical therapy services can be performed in a freestanding facility or the offices of a doctor of medicine (M.D.) or osteopathy (D.O.) or independent physical therapist (IPT). Before receiving treatment, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday for information on approved facilities, procedures and diagnoses.

Pulmonary rehabilitation

The medical plan covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease.

Radiation therapy

The medical plan covers radiation therapy including X-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigative. Radiation therapy (oncology) services rendered by plan providers will require prior authorization. Your plan provider will arrange for this prior authorization, if needed.

Second opinion on surgery

The medical plan covers second surgical opinions in some cases for surgery that isn't an emergency. In some cases the medical plan covers third surgical opinions.

Speech therapy

The medical plan covers rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery when your doctor or other healthcare provider certifies you need it. These services are covered only when the services are specific, safe, provided for rehabilitation and an effective treatment for your condition.

To qualify for coverage, therapy must address a condition that can be improved within a reasonable and generally predictable time frame (typically around six months), or it must aim to optimize your developmental potential or maintain your current level of functioning.

Speech therapy services can be performed in a freestanding facility or in the office. Before receiving treatment, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday for information on approved facilities, procedures and diagnoses.

Temporomandibular (TMJ) or Jaw-Joint Disorder

The medical plan will cover reversible treatment for jaw-joint disorders. Reversible treatment is treatment of the mouth, teeth or jaw that is not intended to effect a permanent alteration of the bite (occlusion) and is directed at managing symptoms. It can include, but is not limited to, physical medicine, medications or reversible appliance therapy.

The medical plan does not cover irreversible medical, surgical and/or dental treatment of the mouth, jaw and associated structures. Irreversible treatment is treatment of the mouth, teeth or jaw that is intended to effect a permanent change in the positioning of the jaws or permanent alteration of the vertical bite dimension. It includes, but is not limited to, crowns, inlays, caps, restorations, grinding, orthodontics and the installation of removable or fixed appliances such as dentures, partial dentures or bridges.

Exceptions: The medical plan does cover irreversible surgery directly to the temporomandibular joint, X-rays (including MRIs) and arthrocenteses (injections), regardless of the cause of the jaw-joint disorder. Jaw-joint disorders include, but are not limited to, muscle tension and spasms of musculature related to the temporomandibular joint, skeletal defects and occlusal defects (problem of the bite), that cause pain, loss of function, neurological and personality dysfunctions. This also includes temporomandibular joint syndrome, craniomandibular disorders and myofacial pain dysfunction syndrome.

Virtual care visits

The medical plan covers virtual care visits, sometimes called telehealth. Virtual care visits give you the opportunity to meet with a healthcare provider through electronic forms of communications. This allows you to meet with a healthcare provider for minor illnesses or conditions that require medical attention when it is not possible for you to meet with your primary care provider in the office. Certain telehealth services are covered, including visits with primary care providers and individual sessions with mental health providers.

You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a provider who offers the service by telehealth.

You can access virtual medical and behavioral health services anywhere in the United States. You may choose to have a virtual care visit with your own provider, if your provider offers this service. Refer to the *Virtual visits* section of this booklet for more information.

Vision services

The medical plan covers the examination and fitting of one pair of corrective lenses (eyeglasses with standard frames) or one set of contact lenses prescribed by a physician following cataract surgery in one or both eyes.

The medical plan covers medical eye exams which produce a diagnosis, such as cataracts, glaucoma, dry eye or conjunctivitis. A medical eye exam differs from a routine vision exam in that it is an exam where you are evaluated or treated for some sort of medical condition. Routine eye exams check your vision, screen for eye diseases, and/or updating eyeglasses or contact lenses.

The medical plan does not cover routine eye examinations, preparation, fitting or procurement of eyeglasses or other corrective visual appliances except as described above.

Preventive services

What you pay	
In PPO network	**Outside PPO network**
You pay nothing, unless otherwise noted below.	20% of the amount approved by Blue Cross, unless otherwise noted below. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

If you're treated or monitored for an existing medical condition when you receive a preventive service, you'll have an out-of-pocket cost for the care received for the existing medical condition.

Adult vaccinations

The medical plan covers the following vaccinations at no cost to you in network and out of network.

Vaccine category	Vaccine brand name	
Chikungunya Virus	Ixchiq	
Cholera	Vaxchora	
Coronavirus (COVID-19)	Janssen Covid-19 Vaccine Moderna Covid Vaccine Moderna Covid-19 Bival Booster Moderna Covid-19 Vac (Booster) Moderna Covid-19 Vacc 6m-5Y Novavax Covid-19 Vaccine Pfizer Biontech Covid-19 Vac Tris	Pfizer Biontech Covid-19 Vaccine Pfizer Covid-19 Vac 6m-4 y Pfizer Covid-19 Vac Bival 5-11 Pfizer Covid-19 Vac Bivalent Pfizer Covid-19 Vac Tris 5-11 Y Sanofi Covid-19 (booster) Spikevax Covid-19 Vaccine
Dengue	Dengvaxia	
Haemophilus B	Acthib, Hiberix, Pedvax	
Hepatitis A	Havrix, Twinrix*, Vaqta	
Hepatitis B (Hep B)	Engerix-B, Heplisav-B, Pediarix, Prehevbrio, Recombivax HB, Twinrix*	
Human Papillomavirus (HPV)	Gardasil 9	
Influenza (Flu)	Afluria Quadrivalent Fluad Quadrivalent Fluarix Quadrivalent Flublok Quadrivalent	Flucelvax Quadrivalent Flulaval Quadrivalent Flumist Quadrivalent Fluzone Quadrivalent
Japanese Encephalitis	Ixiaro	
Measles, Mumps, Rubella	MMR II, Priorix	
Meningococcal	Bexsero, Menactra, Menquadfi, Menveo, Penbraya, Trumenba	
Monkeypox; Smallpox	Jynneos	
Pneumococcal (pneumonia)	Capvaxive, Pneumovax 23, Prevnar 13, Prevnar 20, Vaxneuvance	
Polio	Ipol	
Rabies	Imovax, Rabavert	
Respiratory Syncytial Virus (RSV)	Abrysvo, Arexvy, Mresvia	
Rotavirus	Rotarix, Rotateq	
Shingles	Shingrix	
Tetanus	Adacel*, Boostrix*, Daptacel*, Diphtheria-Tetanus Toxoids DT*, Infanrix*, Kinrix*, Pentacel*, Quadracel*, Tdvax*, Tenivac*, Vaxelis*	
Tick-Borne Encephalitis	Ticovac	
Tuberculosis	BCG Vaccine	
Typhoid	Typhim	
Varicella (Chickenpox)	Proquad*, Varivax, Varizig	
Yellow Fever	Stamaril, YF-Vax	

*Combination product that contains other vaccines.

Breast cancer screening (mammograms)

The medical plan covers one routine, screening mammogram (breast X-ray) every calendar year.

When a sign or symptom is discovered during an exam, all further testing and exams are considered diagnostic procedures and diagnostic out-of-pocket costs will apply. Refer to the *Other diagnostic services* section of this booklet for more information.

Cervical and vaginal cancer screening

Pap tests and pelvic exams to check for cervical and vaginal cancers are covered once every calendar year.

Colorectal cancer screening

Screening colonoscopy is covered once every 120 months (high risk every 24 months).

When a sign or symptom is discovered during an exam, all further testing and exams are considered diagnostic procedures and diagnostic out-of-pocket costs will apply. When a polyp is found and removed during a colonoscopy screening, your colonoscopy is considered diagnostic and diagnostic out-of-pocket costs will apply. Refer to the *Other diagnostic services* section of this booklet for more information.

Physical exam

The medical plan covers a routine physical exam and standard, routine labs done in conjunction with the physical exam once per calendar year.

Prostate cancer screening

The medical plan covers a routine screening Prostate Specific Antigen (PSA) test once every calendar year. Refer to the *Laboratory services* section in this booklet for more information.

Diabetes treatment, services and supplies

Diabetes self management training

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers diabetes outpatient self management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication and reducing the risk of diabetes complications. You must have diabetes and a written order from your doctor or other qualified medical care provider.

Diabetic supplies and medications

What you pay
Blue Cross participating and non-participating independent medical supplier
You pay nothing.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Refer to the chapters in this booklet about hospital benefits and doctor's office benefits for information about obtaining items from those locations. This section does not apply to items you use during a hospital stay or purchase from your doctor.

Items that you purchase or rent from an independent medical supplier must be prescribed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) for use at home. If you need medical supplies, the quantity you receive will be based on your prescription and the medical necessity guidelines used by Blue Cross Blue Shield of Michigan.

Some diabetic supplies are covered under your medical plan while others are covered under your prescription drug plan.

The medical plan covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, and blood sugar control solutions.

The medical plan covers the following for people who have diabetes and severe diabetic foot disease:

- The furnishing and fitting of either one pair of custom-molded shoes, one pair of extra-depth shoes, inserts, or shoe modifications each calendar year.
- Two additional pairs of inserts for custom-molded shoes and three pairs of inserts for extra-depth shoes each calendar year.

The therapeutic shoes and inserts listed above must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist or other qualified individual.

Injectable insulin and needles and syringes for injectable insulin are covered under your prescription drug plan when prescribed by your physician.

Dialysis treatment, services and supplies

Dialysis treatment and services

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers treatment for chronic, irreversible kidney disease in the outpatient department of a hospital and renal dialysis facility when arranged by your doctor and billed through a network provider or participating hospital. Dialysis is also covered if you're admitted as an inpatient to a hospital for special care. Refer to the chapters in this booklet about hospital benefits and doctor's office benefits for information about receiving care from those locations.

The PPO network does not include home dialysis providers, but the medical plan will cover this service in your home if the provider is approved by Blue Cross. Home dialysis services include the acquisition and installation of a dialysis machine, training in the operation of the machine, necessary laboratory tests, visits by trained dialysis workers, support services, drugs required during the dialysis and consumable supplies.

Dialysis supplies

What you pay	
Blue Cross participating independent medical supplier	**Non-participating independent medical supplier**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible, and the difference between the supplier's charge and the amount approved by Blue Cross.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Refer to the chapters in this booklet about hospital benefits and doctor's office benefits for information about obtaining items from those locations. This section does not apply to items you use during a hospital stay or purchase from your doctor.

Items that you purchase or rent from an independent medical supplier must be prescribed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) for use at home.

If you need home dialysis equipment and supplies, the quantity you receive will be based on your prescription and the medical necessity guidelines used by Blue Cross Blue Shield of Michigan.

Laboratory services

Laboratory services are tests of body fluid or tissue that help your doctor diagnose a disease or an injury. Covered services include:

- Pap tests and Prostate Specific Antigen (PSA) tests if requested by your physician because of a suspected or actual presence of disease.*
- Blood tests.
- Urine tests.
- Pathology services (laboratory examination of tissue).

**Refer to the Preventive services section in this booklet for more information.*

Most often your doctor will collect a specimen from you and send it to a laboratory for processing. In Michigan, Blue Preferred® PPO doctors are responsible for sending your specimens to Quest Diagnostics for processing. If you need to go directly to a lab for tests in Michigan, you have no out-of-pocket cost when you use Quest laboratories. If your Michigan doctor is not in the Blue Preferred PPO network, ask them to send the specimen to a Quest Diagnostics lab.

COVID-19 (coronavirus) tests

What you pay	*In PPO network*	*Outside PPO network*
At an independent lab	10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)
At a provider's office		
At an outpatient hospital		

Tests at an independent laboratory

What you pay	*In PPO network*	*Outside PPO network*
Michigan lower peninsula	You pay nothing at a Quest Diagnostics lab.	If the provider does not participate with Blue Cross, you pay the difference between the provider's charge and the amount approved by Blue Cross.
Michigan upper peninsula and outside Michigan	10% coinsurance, after the annual deductible (Locate network providers using **bcbs.com**).	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Tests in your doctor's office

What you pay	*In PPO network*	*Outside PPO network*
In Michigan	You pay nothing.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)
Outside of Michigan	10% coinsurance, after the annual deductible.	

Refer to the Exclusions and Limitations section of this booklet for additional information.

Other diagnostic services

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

When medically necessary and performed in an approved location, the medical plan covers diagnostic services, including:

- X-rays, CAT scans, MRIs, PET scans and other radiology services.
- EEGs, EKGs, ECGs and EMGs.
- Mammograms if requested by the physician because of a suspected or actual presence of disease or when required as a post-operative procedure.
- Nerve conduction studies.
- Colorectal cancer screenings if a physician finds and/or removes an abnormality, polyp or other tissue.
- Ultrasounds.

The medical plan requires that network providers obtain prior authorization for specific high technology diagnostic radiology services. Your provider will arrange for this prior authorization. Prior authorization does not apply to emergency room care.

Behavioral health, mental health and substance use disorder services

The medical plan covers behavioral health, mental health and substance use disorder services to help with conditions such as depression or anxiety. Coverage includes services generally provided in an outpatient setting (such as a doctor's or other healthcare provider's office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, licensed master social worker, nurse practitioner, physician assistant, or clinical nurse specialist. Treatment for substance use disorder is payable for services rendered in an approved residential facility. A residential substance use disorder treatment facility may be a freestanding facility exclusively treating substance use disorder, or a hospital-based treatment center. Laboratory tests are also covered. Certain limits and conditions apply.

Services in an outpatient behavioral and mental health facility

What you pay	
Facility approved by Blue Cross	**Non-approved facility**
10% coinsurance, after the annual deductible.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Behavioral and mental health treatment in an approved outpatient behavioral and mental health facility includes:

- All services of professional and other trained staff, and related services necessary for your care.
- Prescribed drugs and medications related to your treatment administered in the facility.
- Electroshock therapy and anesthesia administered by a physician.
- Psychological testing once every 12 months when administered by a fully licensed psychologist employed by or having privileges at the facility.
- Counseling for your family members.

Services in a substance use disorder facility

What you pay	
Facility approved by Blue Cross	**Non-approved facility**
10% coinsurance, after the annual deductible.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Substance use disorder services include:

- Services of professional and trained staff, and services necessary for your care and treatment, including diagnostic tests.
- Individual and group therapy or counseling.
- Psychological testing once every 12 months.
- Laboratory examinations related to your treatment in the program.
- Drugs, biologicals and solutions related to your treatment in the program.
- Supplies and use of equipment required for detoxification or rehabilitation.
- Counseling for your family members.

If you're admitted to a residential substance use disorder treatment program, the medical plan also covers bed, board and general nursing care during your admission, in addition to the services listed above. Inpatient care for up to five days of detoxification is payable under the inpatient hospital benefit.

Make sure your treatment facility is approved by Blue Cross
Before you enter a treatment program, make sure it's approved by Blue Cross. Treatment at non-approved facilities is not covered under the medical plan. You can verify if the treatment facility is approved by calling Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Services in a physician's office

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

Behavioral and mental health treatment is also payable for services rendered in a physician's office, including counseling for you and your family members, and psychological testing prescribed, rendered and billed by a fully licensed psychologist once every 12 months.

Nursing care

Skilled nursing facility care

What you pay	
Facility approved by Blue Cross	**Non-approved facility**
10% coinsurance, after the annual deductible.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan will cover 100 days of medically-necessary care in a skilled nursing facility approved by Blue Cross. After you've been discharged from the skilled nursing facility for at least 60 consecutive days, you become eligible for another 100 days of care. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care, such as intravenous injections or physical therapy.

Your skilled nursing benefits include:

- Semiprivate room and board (or a private room if medically necessary).
- Meals, including special diets.
- General and skilled nursing care.
- Physician/practitioner services.
- Physical, occupational and speech therapy.
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.).
- Blood, including storage and administration.

- Medical and surgical supplies ordinarily provided by the facility.
- Laboratory tests ordinarily provided by the facility.
- X-rays and other radiology services ordinarily provided by the facility.
- Use of appliances, such as wheelchairs, ordinarily provided by the facility.

The medical plan does not cover custodial or domiciliary care, or care for intellectual disability or senile deterioration.

Home health agency care

What you pay	
Provider approved by Blue Cross	**Non-approved provider**
You pay the annual deductible.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Home healthcare is covered for patients confined to home if medically necessary and provided by a home healthcare agency approved by Blue Cross. Your physician must prescribe the care and prepare a treatment plan.

Confined to home means both of these are true:

- You have trouble leaving your home without help (such as using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort.

A doctor, or certain qualified medical care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home healthcare.

At each visit, the medical plan will cover:

- Part-time or intermittent skilled nursing care by an employee of the home healthcare agency.
- Part-time or intermittent home health aide services such as meal preparation, bathing and feeding.
- Nutritional guidance and medical social services.
- Medical and surgical supplies such as catheters and colostomy supplies, oxygen, laboratory services and medications for use at home (Refer to the *Medical equipment, prosthetics, orthotics and supplies* section for information on your costs.).
- Physical, occupational and speech therapy (may be covered outside the home when equipment cannot be brought into the home). These services are covered only when the services are specific, safe, provided for rehabilitation and an effective treatment for your condition. To qualify for coverage, therapy must address a condition that can be improved within a reasonable and generally predictable time frame (typically around six months), or it must aim to optimize your developmental potential or maintain your current level of functioning.

  Note: To be covered under the home healthcare benefit, your skilled nursing and home health aid services combined must total fewer than eight hours per day and 35 hours per week.

Hospice care

What you pay	
Provider approved by Blue Cross	**Non-approved provider**
You pay nothing.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan will pay for care provided in an approved hospice care program up to the specified number of days described below. **Your decision to receive hospice care is entirely voluntary and can be canceled by you at any time.**

Electing hospice benefits

To qualify for hospice benefits you must be terminally ill, as certified by a physician, and have a medical prognosis that indicates a life expectancy of 12 months or less.

You may elect to receive hospice benefits by filing an election statement with an approved hospice program. An election statement is a document that you sign to declare that you elect to receive hospice benefits and waive your rights to receive Blue Cross benefits (both inpatient and outpatient) for conditions related to your terminal illness. Each hospice program designs its own election statement.

Note: *If you elect hospice benefits, you're still eligible to receive medical plan benefits, but not for those conditions related to your terminal illness.*

Hospice benefits are divided into four election periods:

- One period of 90 consecutive days.
- A second period of 90 consecutive days.
- A third period of 90 consecutive days.
- A fourth period of 90 consecutive days.

You may continue to use your hospice benefit periods until you exhaust all four periods or cancel your hospice benefits.

Levels of hospice care

You're entitled to the following levels of hospice care:

- **Home care services** in periods of one- to eight-hours per day, or continuous home care up to 24-hours per day during crisis periods.
- **Facility services** provided by a participating hospice inpatient unit, or by a participating hospital or skilled nursing facility that has a contract with Blue Cross Blue Shield of Michigan to provide hospice care. These facilities can provide:
  - **Occasional respite care** to relieve family members or other persons caring for you at home. When necessary, up to five days of respite care is covered within a 30-day calendar period.
  - **Short-term general inpatient care** for pain control or symptom management, to the extent such care is consistent with the plan of care established by the hospice program.

Hospice care benefits

When admitted to an approved hospice program, you're entitled to the following services:

- Physician services by a member of the hospice care program.
- Nursing care by, or under the supervision of, a registered nurse.
- Medical social services by a qualified social worker and under the direction of a physician.
- Coverage for evaluation, consultation, and supportive services for the patient and family.
- Counseling services provided to you and your family members (or other persons caring for you at home).
- Medical appliances and supplies, including drugs and biologicals, furnished to relieve pain or lessen the effects of the terminal illness.
- Durable medical equipment furnished by the hospice program for use in your home while you're under hospice care.
- Home health aide services provided by qualified aides, and homemaker services rendered under the general supervision of a registered nurse.
- Physical and occupational therapy, and speech language pathology services provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills.
- Bereavement counseling for your family after your death.

Canceling hospice benefits

You may discontinue hospice care at any time by submitting a cancellation statement to the hospice program administrator. You or the hospice program can develop the cancellation statement, which must include:

- Your acknowledgment that you're canceling hospice benefits for the remainder of the current election period.
- The effective date of the cancellation of hospice benefits.
- Your Blue Cross member ID number and group number.
- Your signature.

When you cancel hospice benefits, your regular medical plan benefits will be reinstated without any lapse of coverage.

You may cancel hospice benefits a maximum of four times: once per election period. You can cancel at any time within an election period, and Blue Cross will reinstate benefits for your care. However, if you cancel hospice benefits, you forfeit any unused days in the 90-day election period in effect when you canceled hospice care.

Hospice benefit limitations and exclusions

Hospice care is subject to the following limitations and exclusions:

- Benefits include only those services provided primarily in connection with the terminal illness by the hospice program.
- Benefits are limited to services of an approved hospice program you designate, unless your designated hospice program makes arrangements with another approved hospice program to provide services.
- Benefits include only those services that are part of the plan of care established by the hospice program.

Medical equipment, prosthetics, orthotics and supplies

What you pay	
Blue Cross participating independent medical supplier	**Non-participating independent medical supplier**
10% coinsurance, after the annual deductible.	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible, and the difference between the supplier's charge and the amount approved by Blue Cross.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Refer to the chapters in this booklet about hospital benefits and doctor's office benefits for information about obtaining items from those locations. This section does not apply to items you use during a hospital stay or purchase from your doctor.

Items that you purchase or rent from an independent medical supplier must be prescribed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) for use at home.

If you need medical supplies, the quantity you receive will be based on your prescription and the medical necessity guidelines used by Blue Cross Blue Shield of Michigan.

Types of equipment, supplies and services include:

- Durable medical equipment used in your home, such as hospital beds, wheelchairs, walkers, canes and oxygen equipment.
- Respiratory equipment such as oxygen concentrators and apnea monitors.

- Prosthetic devices such as artificial limbs and mastectomy supplies.
- Orthotic devices such as leg braces, back braces and ankle or wrist supports.
- Medical supplies such as colostomy supplies, surgical dressings, adult disposable diapers, surgical stockings (up to eight per year) and home infusion needles.
- Equipment setup and training when medically necessary, such as assistance by an RN or respiratory therapist.
- Orthopedic shoes are covered when medically necessary for people with a diabetes diagnosis and for people who do not have diabetes.

Transplants

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible, unless otherwise noted. If you have a specified organ transplant, you have coverage for reasonable and necessary travel and lodging up to $10,000 maximum for you and one companion (two companions if the patient is under age 18 or the transplant involves a living donor related to the patient).	10% coinsurance plus an additional 20% of the Blue Cross approved amount, after the annual deductible, unless otherwise noted. (If provider does not participate with Blue Cross Blue Shield, you also pay the difference between the provider's charge and the amount approved by Blue Cross.)

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan will pay for organ and tissue transplants, bone marrow transplants and specified organ transplants approved by Blue Cross Blue Shield of Michigan and performed at a participating hospital or a designated transplant facility approved by Blue Cross Blue Shield of Michigan.

Transplant coverage includes:

- Hospital and medical costs.
- Transplant-related services, such as tests, labs, and exams before surgery.
- Services needed to treat a condition arising out of the organ transplant surgery.
- Travel and lodging (up to a $10,000 maximum under certain conditions).
- Evaluation and surgical removal of the donated part from a living or nonliving donor and surgically transplanting the part to you.
- Procurement of organs.
- Follow up care.

Obtaining prior authorization for transplant surgery

Prior to surgery, your physician must request prior authorization from Blue Cross Blue Shield of Michigan for certain transplants. This prior authorization is necessary to ensure that your surgery is covered by the medical plan and performed in a designated transplant center meeting established standards. Prior authorization for the transplant will be sent to the transplant center or the physician (whomever requests the prior authorization) and to you.

Immunosuppressive drugs

Transplant surgeries are covered by your Blue Cross medical plan. However, immunosuppressive drugs prescribed to transplant patients are covered by your prescription drug plan.

Organ and tissue transplants

Covered services include the evaluation and surgical removal of the donated part (including skin, corneas, kidneys and the specified organs listed under the *Specified organ transplants* section of this booklet) from a living or nonliving donor and surgically transplanting the part to you.

Bone marrow and stem cell transplants

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow of another person (called allogeneic transplants) or using the patient's own bone marrow or peripheral blood stem cells (called autologous transplants) for transplantation back into the patient. This procedure is used to treat certain types of cancer.

Bone marrow transplants are payable only for approved diagnoses. Your physician must obtain prior authorization from Blue Cross Blue Shield of Michigan prior to your surgery. **This prior authorization is necessary to ensure that your diagnosis is covered under the bone marrow transplant benefit and that your surgery will be performed in a location approved by Blue Cross and by an approved provider.**

Additional covered services for autologous and allogeneic bone marrow and/or peripheral stem cell transplants include:

- Blood tests on first-degree relatives to evaluate them as donors (if these services are not already covered by their medical insurance).
- A search of a bone marrow donor registry for a donor. (A search will begin only when the need for a donor is established. The registry's name and charges must be submitted for approval to Blue Cross Blue Shield of Michigan by the bone marrow transplant center.)
- Infusion of colony-stimulating growth factors.
- Harvesting of bone marrow and/or stem cells and associated storage costs if transplant is intended within one year.
- ECP (Extracorporeal Photopheresis for Graft vs. Host Disease) for treatment of transplanted cells/tissues that attack and destroy the tissues/organs of the transplant receipt.
- Hospitalization in an intensive care or special care unit.
- Infusion of bone marrow and/or stem cells into the patient.
- Services received when you donate bone marrow and/or peripheral blood stem cells.

Travel and lodging is not covered for bone marrow transplants.

Specified organ transplants

You have coverage for travel and lodging to and from the designated facility for the following organ transplants:

- Heart.
- Heart-kidney.
- Heart-liver.
- Heart-lung.
- Intestine.
- Liver.
- Lung.
- Lobar lung.
- Pancreas.
- Stomach.
- Multivisceral transplants (multiple abdominal organs) as determined by Blue Cross.

Travel and lodging to and from the designated facility for the transplant surgery is covered without out-of-pocket costs to you, up to a $10,000 maximum. Reasonable and necessary costs are covered for you and one companion (two companions if the patient is under age 18 or the transplant involves a living donor related to the patient).

Travel and lodging is not covered for other types of transplants.

Cost of acquiring the donor organ is covered, including surgery, storage, transportation and payment of covered services if the donor does not have transplant services under any medical plan. If the organ is obtained from a non-living donor, costs incurred by the donor before death are not covered.

For additional information about transplants and designated transplant facilities, call the Blue Cross Human Organ Transplant Program at **1-800-242-3504** (TTY: **711**) from 8 a.m. to 5 p.m. Eastern time, Monday through Friday.

Religious non-medical healthcare institution

What you pay	
Provider approved by Blue Cross	**Non-approved provider**
10% coinsurance, after the annual deductible.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, the medical plan will only cover the inpatient, non-religious, non-medical items and services. An example is room and board, or any items and services that don't require a doctor's order or prescription, such as unmedicated wound dressings or use of a simple walker.

Routine hearing care

What you pay	
TruHearing provider	**Non-TruHearing provider**
• $45 copay for routine hearing exam. • $499 copay per TruHearing Advanced hearing aid. • $799 copay per TruHearing Premium hearing aid.	You pay all costs.

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your routine hearing care benefits are exclusively available through a national network of TruHearing providers. Routine hearing care services and hearing aids are only covered when you call TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. and follow the directions you're given. TTY users should call **711**. Your routine hearing care benefits are not subject to the annual deductible. Copays for routine hearing exams and hearing aids aren't included in the annual coinsurance maximum.

Your routine hearing benefits include the following services:

Audiometric examination

Audiometric examination measures hearing ability, including test for air and bone conduction, speech reception and speech discrimination.

Hearing aid evaluation test

Hearing aid evaluation test determines what type of hearing aid should be prescribed to compensate for loss of hearing.

Hearing aids

TruHearing Advanced or TruHearing Premium monaural (one ear) and binaural (involving both ears) in various fits, styles and colors are covered under your medical benefits. Other hearing aids are not covered.

TruHearing provides the following:

- One year of follow-up visits.
- 60-day trial period.
- Three year manufacturer warranty.
- 80 batteries per non-rechargeable hearing aid.

Using your hearing care benefits

Call TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. to schedule an appointment. TTY users should call **711**.

TruHearing will:

- Verify benefit eligibility and answer your questions.
- Schedule your appointment with a local provider.
- Send you an appointment reminder.
- Follow up after your hearing exam to ensure satisfaction.

Frequency limitation

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. and follow the instructions you're given. TTY users should call **711**. Routine hearing exams are covered once every 36 months. Up to two TruHearing Advanced or TruHearing Premium hearing aids are available every 36 months.

Note: Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they are purchased on the same date. Two hearing aids provided to you on different dates are not considered binaural hearing aids and only one will be paid during a 36-month period.

Payment provisions

1. Routine hearing care services must be received from a TruHearing provider to be covered.
2. Copays for routine hearing exams and hearing aids aren't counted toward your deductible and aren't included in the annual coinsurance maximum.

Exclusions and limitations

The following exclusions and limitations apply to your medical plan benefits. These conditions are in addition to other applicable exclusions and limitations listed elsewhere in this booklet.

- Services provided before the effective date of coverage or after the coverage termination date.
- Any charges for care, treatment, service or supplies to the extent such charges exceed Blue Cross Blue Shield's determination of the amount of reasonable charges.
- Services and supplies considered not reasonable and necessary, according to the standards of Blue Cross Blue Shield of Michigan, for the diagnosis or treatment of the illness or injury, unless these services are listed as covered elsewhere in this benefit booklet.

- Routine health screenings and preventive services except as otherwise specified in this booklet. Exclusions include but are not limited to: abdominal aortic aneurysm screening, alcohol misuse screening and counseling, blood-based biomarker test, bone mass measurement (bone density), cardiovascular disease behavioral therapy, cardiovascular disease screenings, depression screening, diabetes prevention program, diabetes screenings, EKG or ECG screening, Federally Qualified Health Center (FQHC) services, glaucoma tests, Hepatitis B screening, Hepatitis C screening, HIV screening, HPV tests, lung cancer screening with low-dose computed tomography, obesity screening and counseling, routine foot exams and care, screening barium enema, screening digital rectal exams, and sexually transmitted infections screening and counseling.
- Services for premarital and preemployment examinations.
- Tobacco-use cessation services are only covered when provided by the Blue Cross Well-Being Tobacco Cessation Coaching program.
- Kidney disease education services.
- Medical nutrition therapy services, except as described elsewhere in this benefit booklet.
- Services for cosmetic or beautifying purposes unless required for the correction of a defect incurred through an injury or for the correction of a congenital anomaly or breast reconstruction.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Voluntary sterilization, reversal of sterilization, sex change operations, contraceptive supplies. Check with your prescription drug plan about coverage for oral contraceptives.
- Surgical treatment for morbid obesity, except when it is considered medically necessary.
- Services for detoxification for drug addiction or alcoholism except for treatment of the underlying causes and for services leading to rehabilitation.
- Behavioral and mental health services extending beyond the period necessary for evaluation and diagnosis for intellectual disability.
- Services and supplies not medically necessary. For a definition of medical necessity, refer to the *Glossary of medical care terms*.
- Private room in a hospital.
- Custodial or domiciliary care.
- Rest therapy and care in nursing or rest home facilities.
- Care for intellectual disability or senile deterioration.
- Personal care items.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Private duty nursing.
- Full-time nursing care in your home.
- Hospital admissions principally for observation or diagnostic evaluation, physical therapy, X-ray or laboratory tests, weight reduction (with or without medication), basal metabolism tests, electrocardiography, ultrasound studies or nuclear medicine studies.
- Treatment for conditions that do not require substantially continuous bed care under the constant care of licensed physicians and registered nurses.
- Hospital care for dental services except for services rendered when you're a hospital bed patient for either multiple extractions or the removal of unerupted teeth, performed under a general anesthesia when a concurrent hazardous medical condition exists.
- Treatment of temporomandibular joint (TMJ) syndrome and related jaw-joint problems by any method other than direct surgery on the jaw joint, X-rays or arthrocenteses (injections).
- Routine dental care, such as cleanings, fillings or dentures.

- Chiropractic care, other than manual manipulation of the spine and spinal X-rays.
- Items such as air purifiers, air conditioners and exercise equipment.
- Adjustment or replacement of eligible appliances unless required because of wear or a change in your condition.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids, except for corrective lenses covered following cataract surgery as described elsewhere in this booklet.
- Prescription drugs except as otherwise specified in this booklet.
- Separate charges for infiltration of a local anesthetic during a surgical procedure.
- Massage therapy.
- Physical therapy solely for pain management.
- Tests to measure physical capacities, such as strength, dexterity, coordination or stamina unless part of a complete physical therapy treatment program.
- Recreational services.
- Services and items primarily for your comfort and convenience.
- Cost of transportation and travel, except for ambulance service and specified organ transplant benefits specified in this booklet.
- Ambulance transportation not medically necessary.
- Transportation in a vehicle not state-certified as an ambulance.
- Services rendered by fire departments, rescue squads or other carriers whose fee is paid as a voluntary donation.
- Cadaver transport.
- Transportation in connection with outpatient care for a non-accidental illness.
- Transportation for your and your family's convenience or doctor and hospital preference.
- Homemaker services and household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Home-delivered meals.
- Charges for the completion of claim forms.
- Charges for missed appointments.
- Services, care, supplies or devices considered experimental or investigative, including clinical research studies and all services associated with clinical research studies. For a definition of experimental/investigative, refer to the *Glossary of medical care terms*.
- Acupuncture.
- Naturopath services (use of natural or alternative treatments).
- Treatment of an illness or injury caused by military action or war, declared or undeclared.
- Care and services you receive at no cost to you when provided in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency, unless required by law.
- Services provided to veterans in Veterans Affairs (VA) facilities except for the difference in cost-share if emergency services are received and the VA cost-share is more than the cost-share under this medical plan.
- Care and services payable by a government-sponsored healthcare program, such as Medicare or TRICARE, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs.
- Cost of care and services covered by another insurance plan that has primary responsibility for first payment.

- Injury or sickness covered by workers' compensation.
- Care of an occupational injury or disease for which the employer is obligated to provide reimbursement for services.
- Cost of installation of water, electrical or waste systems in a residence where such systems are not present.
- Cost of water or electricity used in the operation of a dialysis machine.
- Costs incurred in the installation of a dialysis machine which are not essential to its operation.
- Installation cost incurred in moving a dialysis machine to another location within the patient's residence.
- Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. and follow the instructions you're given.
- Hearing care benefit does not include or cover any of the following items or services under any circumstances:
  - Hearing aids other than TruHearing Advanced and TruHearing Premium hearing aids.
  - Ear molds.
  - Hearing aid accessories.
  - Provider visits for hearing aid adjustments after the first year (additional visits may cost up to $65).
  - Extra batteries beyond the first 80 provided per aid (additional batteries may be purchased from TruHearing on a discounted basis).
  - Charges associated with loss and damage warranty claims (may cost up to $250 per hearing aid for manufacturer and provider programming fees).
  - All hearing program services and supplies provided by a provider not associated with TruHearing.
  - Costs associated with excluded items.
  - Charges associated with seeing a provider outside of the TruHearing network.

Subrogation

In certain cases, another person, insurance company or organization may be legally obligated to pay for medical services that Blue Cross has paid. Subrogation is the legal process by which Blue Cross recovers these payments. If you're awarded compensation for medical services already paid by Blue Cross:

- Your right to recover payment from the other person, insurance company or organization is automatically transferred to Blue Cross.
- You're required to fully cooperate with Blue Cross to help enforce its right to recovery.
- If you receive money through a lawsuit, settlement or other means for services paid under your medical coverage, you must reimburse Blue Cross.

Filing claims

Ask your provider to bill Blue Cross Blue Shield for covered services. Some nonparticipating providers will file a claim or assist you with claim filing. Do not file a claim if your provider is billing Blue Cross Blue Shield for the services. If the provider gives you a receipt, just keep it for your records.

If you receive services from a provider that does not participate with Blue Cross Blue Shield, and the provider will not file your claim, you will need to file it. Unless otherwise noted, you must file your claim to Blue Cross within 24 months of the date of service. Remember: Payment from Blue Cross Blue Shield of Michigan is made to you; it's your responsibility to pay the provider. Charges for filing claims are not covered.

Filing claims for COB

In most instances, when you go to a participating provider, your provider will bill the primary and secondary plans directly. However, if you receive services from a nonparticipating provider and the provider will not file your claim, you will need to do so.

How to file a claim

1. Ask for an itemized statement of services at the time of service. Your itemized receipt must contain the following:
    - Name, address and telephone number of the provider (physician, hospital, etc.).
    - Provider's identification number (outside Michigan, you need the tax ID).
    - The retiree's nine-digit identification number from their Blue Cross membership card.
    - Patient's full name and date of birth.
    - Exact date (month, day, year) the service was performed or supplied.
    - Diagnosis.
    - Type of service performed or item supplied.
    - Amount charged for each service performed or item supplied.
    - For services received from a physician in a clinic, make sure the name and license number of the physician who provided the service is indicated on the receipt plus the name of the clinic.
    - For ambulance services, ask for an itemization of the provider's base rate, total miles traveled, location of patient pickup and delivery, and reason for ambulance service. Include the names of hospitals if you're moved from one hospital to another; the accident scene or home address if you're moved to, or from a hospital.
    - For Coordination of Benefits claims, always submit your claim to your primary payer first. Once the primary payer has approved or rejected your claim, then file a claim to Blue Cross Blue Shield and include the explanation of benefits statement from your primary carrier.
2. File your claims immediately after receiving covered services. It's easier to obtain information needed to process your claim when dates of service are recent.
3. Use one *Member Reimbursement Form* per member on your contract. You can use one claim form for multiple services for the same patient.
    - You can complete the *Member Reimbursement Form* from your online Blue Cross member account at **bcbsm.com/mpsers** or on the Blue Cross mobile app.
4. Review claim forms to ensure the information is accurate and complete and be sure to sign the form.
5. Make copies of all statements and forms for your files before sending the originals. When you submit claims, always make a photocopy of the claim form, receipts and any other supporting documentation that you send to Blue Cross. That way, you'll have a reference in case you have to call us with a question, as well as a permanent record for your files.
6. Mail your request for payment together with any bills or receipts to Blue Cross Blue Shield of Michigan at this address:

    Member Claims, MC 0010
    Blue Cross Blue Shield of Michigan
    600 E. Lafayette Blvd.
    Detroit, MI 48226-2998

Why you should always file claims as soon as possible
You have 24 months from the date of service to file your claims, but why wait? If Blue Cross has questions about the claim, your memory — and certainly your provider's — won't be as clear on the details of the diagnosis and services rendered. But most important, if you've paid for services, why not get your reimbursement now…instead of a year from now?

Explanation of Benefits Statement

Once your claim is processed, Blue Cross Blue Shield of Michigan will send you an explanation of benefits (EOB) statement. The EOB is not a bill. It is provided to help you understand how your benefits were paid and shows:

- Date of service.
- Name of the hospital, physician or other medical care professional that provided each service. If services are performed outside of Michigan, "out-of-state provider" will be indicated.
- Amount billed by your provider.
- Blue Cross' approved amount for each service.
- Any amount you may owe your provider for deductible, copays, coinsurance and non-covered services.
- Any amount applied toward your annual deductible and annual coinsurance maximum.
- An explanation when payment is denied.

The EOB is also provided to make sure the information received was correct. Therefore, it's important that you carefully review your EOB statements to make sure that payments agree with services you actually received and that names and dates agree with your records. If you do find an error, immediately tell your provider and request a corrected statement. If you have questions about your EOB, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Routine hearing care appeals and complaints

What to do if you have a problem or concern

All questions and concerns about your routine hearing care benefits should be directed to TruHearing at **1-855-205-6305**, Monday through Friday 8 a.m. to 8 p.m. TTY users should call **711**. You can contact TruHearing with questions about your routine hearing care benefits, including your eligibility for the benefits or the amount you pay for your routine hearing care benefits or hearing aids. You should contact TruHearing in any of the following situations:

- If you need to know whether a particular service or item is covered.
- If you have a complaint about a TruHearing provider, including a complaint about the quality of your care.

Grievance and Appeal Process

Contact information for Grievances and Appeals	
Call	**1-800-422-9146** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
TTY	**711** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Blue Cross Blue Shield of Michigan Grievance and Appeals Department P.O. Box 2459 Detroit, MI 48231-2459

What to do if you have a problem or concern

Blue Cross Blue Shield of Michigan wants to make sure you're satisfied with the services you receive as a member of the Blue Preferred® PPO plan. If you have a question or concern about how your claim or request for benefits was handled, call Blue Cross Customer Service at **1-800-422-9146** (TTY:**711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. It's also at the top right corner of your explanation of benefits statements.

Most questions or concerns can be resolved through a phone call to Blue Cross Customer Service. If you were unable to resolve your concern through customer service, we have a formal grievance and appeals process.

Grievances are a type of complaint you make about an aspect of operations and activities related to your Blue Cross plan including concerns about providers and the quality of your care.

Appeals are a type of complaint you make when you want Blue Cross to change a decision made about what services your plan covers, or what you'll pay for them.

Under either process, we won't charge you anything extra for filing a grievance or appeal. You may submit written materials or testimony to help us in our review at any step of the grievance or appeals process.

You can also select someone to act on your behalf at any step of the grievance or appeals process, including your physician or provider. Just download and fill out an ***Authorized Representative Form (PDF)*** or call Blue Cross Customer Service and ask to have a form mailed to you. This form gives your representative the permission to communicate with Blue Cross Blue Shield of Michigan on a one-time basis about your concern.

Standard internal grievance and appeals process

1. You or your authorized representative must send Blue Cross a written statement explaining your complaint or why you disagree with the determination on your request for benefits or payment.
2. Once Blue Cross receives your written statement for appeal, a representative will contact you to conduct or schedule the managerial-level conference. That will be your opportunity to provide Blue Cross with any additional information or testimony you want Blue Cross to consider in reviewing your appeal. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at Blue Cross headquarters in Detroit.

3. Blue Cross will provide you with an answer within the following timeframes:
   - Appeals: Blue Cross must provide you with a final written determination within 30 calendar days of its receipt of your written appeal if you are submitting the appeal before you receive the medical service. Blue Cross must provide you with a final written determination within 60 calendar days of its receipt of your written appeal if you are submitting the appeal after you receive the medical service. Blue Cross' written resolution will be the final determination regarding your appeal. You may obtain copies of all information relating to Blue Cross' response free of charge.
   - Grievances: Blue Cross must provide you with a final written determination within 60 calendar days of its receipt of your written grievance. Blue Cross' written resolution will be the final determination regarding your grievance. You may obtain copies of all information relating to Blue Cross' response free of charge.

Expedited internal appeals process

If a provider substantiates orally or in writing that adhering to the time frame for the standard internal appeal 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 appeal.

An expedited internal appeal can only be requested when you think Blue Cross wrongfully denied, terminated, or reduced coverage for a medical service prior to your having received that medical service or if you believe Blue Cross failed to respond timely to a request for benefits or payment.

The procedure is as follows:

1. Call **313-225-6800**. The required provider's substantiation that your condition qualifies for an expedited appeal can also be submitted by telephone.
2. Blue Cross must provide you with its decision within 72 hours of receiving both your appeal and the provider's substantiation. If the decision is communicated to you orally, Blue Cross must provide you with written confirmation within three days.

Disclosure required by the Patient Protection Act

Upon enrollment, Blue Cross 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 Blue Cross Blue Shield of Michigan's Customer Service at the number or address listed in the *How to reach Blue Cross Blue Shield of Michigan* section of this book. You can request:

1. A description of the current provider network in your service area.
2. A description of the professional credentials of participating medical professionals.
3. The licensing verification telephone number for the Michigan Department of Consumer and Industry Services.
4. A description of any prior authorization requirements and any limitations, restrictions or exclusions.
5. A description of the financial relationships between the Blue Cross Blue Shield of Michigan managed care areas and any closed provider network.

Blue Cross requires that your request for information be submitted in writing.

How to reach Blue Cross Blue Shield of Michigan

When calling, be prepared to provide the retiree's nine-digit identification number from your Blue Cross Blue Preferred® PPO membership card.

Blue Cross Customer Service Contact Information	
Call	**1-800-422-9146** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time Toll free from the United States or Canada Call **313-225-9000** outside the United States or Canada and ask to be transferred to the customer area that services Michigan public school retirees. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time Toll free This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	**1-866-458-9342**
Write	Blue Cross Blue Shield of Michigan Michigan Public School Employees' Retirement System 232 S. Capitol Avenue Lansing, MI 48933-1504
Website	**bcbsm.com/mpsers**

Glossary of medical care terms

Acute

A condition that occurs suddenly and rapidly with severe symptoms and short course. This condition is not chronic.

Ambulatory infusion center

An outpatient center, not part of a hospital, where patients can receive medication administered intravenously.

Ambulatory surgical center

An outpatient facility, not part of a hospital, where surgery is performed and care related to the surgery is given. Procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Appeal

A type of complaint you make when you want Blue Cross to change a decision made about what services your plan covers, or what you'll pay for them.

Approved amount

The maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider's charge for the covered service, whichever is lower. Applicable deductible, copay and coinsurance amounts are deducted from the approved amount. All reference to approved amount in this booklet refers to the approved amount as determined by Blue Cross Blue Shield of Michigan.

Benefit

Coverage for medical care services available in accordance with the terms of your medical care coverage.

Benefit period

The medical plan benefit period is a period of 12 consecutive months based on the calendar year, January 1 through December 31. Certain benefits are payable only once during the benefit period and renew each year.

Blue Distinction Centers®

Hospitals recognized for their expertise in delivering specialty care.

Blue Preferred® PPO network provider

A select group of Michigan preferred provider organization (PPO) medical care providers that meet stringent quality requirements and agree to provide services at a lower cost in return for a greater, predictable volume of patients.

Chronic condition

A disease or other medical condition of long duration or frequent recurrence. Chronic conditions usually show little change or are of slow progression.

Coordination of Benefits (COB)

A program that coordinates your medical benefits when you or your covered dependents have coverage under more than one group medical plan.

Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage

A federal requirement that allows departing members to continue group medical coverage at their own cost for a fixed period of time.

Coinsurance

The percentage you pay for the cost of covered medical services. The amount of your coinsurance is based on the amount approved by Blue Cross for covered services.

Coinsurance maximum

The maximum amount you'll pay in coinsurance during a calendar year when using in-network providers.

Copay, copayment

A flat dollar amount that you pay when you receive certain medical care services. Copays are not included in the annual coinsurance maximum.

Cosmetic treatment

Treatment primarily for improving appearance rather than medically treating a disease or other health condition.

Cost-sharing

Amounts that you have to pay when services are received.

Covered service

A service, procedure, treatment, device or supply identified as payable under the medical plan.

Custodial care

Care that is primarily for the purpose of meeting an individual's personal needs or the convenience of the family and can be provided by a person without medical skills or training. The term also includes care that does not require medical supervision that is administered to help a person with activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine, etc. This care may be given with or without routine nursing care, training in personal hygiene and other forms of self-care, or care supervised by a physician.

Deductible

A fixed dollar amount you must pay during each calendar year before covered services and supplies are paid by your retirement system. The deductible is applied before the coinsurance.

Dialysis

Treatment of kidney disease using equipment to remove harmful substances from the blood. Dialysis is one of the primary treatments for end-stage renal disease.

Durable medical equipment

Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. This equipment must be prescribed by a physician and includes items such as wheelchairs, canes, and access railings for the bath.

Emergency, medical emergency

A condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless immediately treated. Examples of medical emergencies include loss of consciousness, severe chest pain, convulsions, etc. Symptoms or conditions such as the common cold, slight fever, headaches, etc., are not considered life-threatening and do not qualify as a medical emergency.

ESRD (end-stage renal disease)

Permanent kidney failure which requires a regular course of dialysis or a kidney transplant to maintain life.

Experimental/investigative

A service or treatment that has not been scientifically demonstrated to be as safe and effective for treatment of a condition as a conventional or standard treatment. Experimental/investigative services are not covered under the medical plan. This includes facility services and physician services, including diagnostic tests, which are related to experimental/investigative procedures. Blue Cross Blue Shield of Michigan's medical director is responsible for determining whether the use of any service is experimental or investigational. The service may be determined to be experimental or investigational when there is:

- A written experimental or investigational plan by the attending provider or another provider studying the same service; or
- A written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy.

Blue Cross Blue Shield of Michigan's medical director uses the following information in the evaluation process:

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

Facility, approved facility

A hospital or clinic that offers acute care or specialized treatment, such as substance use disorder rehabilitation treatment, skilled nursing care or physical therapy. An approved facility must meet all applicable local and state licensing and certification requirements and be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The facility must be approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Grievance

A type of complaint you make about an aspect of operations and activities related to your Blue Cross plan including concerns about providers and the quality of your care.

Home healthcare agency, approved home healthcare agency

A centrally administered agency that provides physician-directed nursing and other paramedical services to patients at home. An approved home healthcare agency is required to be affiliated with a participating hospital, must meet all local and state licensure and certification requirements and must be approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Hospice, approved hospice

A public agency or private program that primarily provides medical, psychological, social and spiritual services to terminally ill individuals and their families. Hospice care may take place in the patient's home, or in an approved facility. An approved hospice program must meet the State of Michigan licensure requirements, must be certified by Medicare and hold membership in the National Hospice Organization or the Michigan Hospice Organization. The hospice provider must also participate in an agreement with Blue Cross Blue Shield of Michigan to accept the approved amount as payment in full.

Hospital, approved hospital

A facility that, in return for compensation from its patients, provides diagnostic and therapeutic services on a continuous inpatient or outpatient basis for the surgical, medical or psychiatric diagnosis, treatment and care of injuries or acutely sick persons. These services are provided by or under the supervision of a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hour-a-day nursing services by registered nurses. A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution for the treatment of the aged or a person who misuses substances or a skilled nursing facility or other nursing care facility. An approved hospital meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Injury

Physical damage caused by an action, object or substance outside the body. Examples include injuries from automobile accidents, sprains or cuts requiring prompt medical treatment, broken bones and frostbite.

Laboratory services

Tests of body fluid or tissue that help your doctor diagnose a disease or an injury. Examples are blood tests, urine tests and Pap smears.

Mammogram

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

Medicaid

A joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

Medical necessity

Services and treatments that are necessary to treat an illness or injury. Unless otherwise specified, only medically necessary services are covered under the medical plan.

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

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

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

Medical necessity for payment of hospital and long-term acute care hospital services:
Determination by Blue Cross that allows for the payment of covered hospital services when all of the following conditions are met:

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

Medical necessity for payment of services of other providers:
Determination by physicians acting for Blue Cross, based on criteria and guidelines developed by physicians for Blue Cross 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.

Medicare

The federally-funded program that pays for medical services to United States citizens age 65 or older, persons of any age who are permanently disabled, or persons with end-stage renal disease.

Network provider

See also: TruHearing provider

A medical care provider selected by Blue Cross Blue Shield of Michigan to provide medical services through the Blue Preferred PPO plan. These providers have signed participating agreements with Blue Cross Blue Shield of Michigan agreeing to accept the approved amount as payment in full for covered services.

Networks in Michigan:

- The Blue Preferred PPO network comprising physicians, hospitals and certain other qualified medical care providers.
- Quest Diagnostics network of independent laboratories.

Networks outside Michigan:

- BlueCard program comprising physicians, hospitals and certain other medical care.

Out-of-pocket

A member's cost-sharing requirement to pay for a percentage of services received.

Outpatient psychiatric facility, approved outpatient psychiatric facility

A legally constituted, centrally administered facility providing comprehensive behavioral and mental health services to the community. An approved facility is an administratively distinct governmental, public, private or independent unit or part of such unit that provides outpatient behavioral and mental health services and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan. These include centers for the care of adults or children, such as hospitals, clinics, day treatment centers and Community Mental Health Centers as defined in the Federal Community Mental Health Act of 1963, as amended.

Outpatient substance use disorder treatment program, approved substance use disorder treatment program

An outpatient program that provides medical and other services specifically for persons who are physiologically or psychologically dependent upon or abusing alcohol or drugs. An approved program meets all state licensure requirements and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Participating provider

A medical care provider who has signed participating agreements with Blue Cross Blue Shield of Michigan agreeing to accept its approved amount as payment in full for covered services. Participating providers may or may not be part of the Blue Preferred PPO network. Participating providers include doctors, hospitals and specialty care facilities, pharmacies and certain other medical care professionals.

Patient

The retiree (subscriber) or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Physician

A doctor of medicine or osteopathy legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. For the purpose of this booklet, a dentist, a podiatrist or a doctor of chiropractic who is legally qualified and licensed to practice dentistry, podiatry or chiropractic at the time and place services are performed is deemed to be a physician to the extent that the doctor renders covered services which the doctor is legally qualified to prescribe or perform.

Prosthetic device

An artificial device that replaces all or part of a body part, or replaces all or part of the functions of a permanently-inoperative malfunctioning body part.

Psychologist

A behavioral and mental health practitioner who is certified or licensed, whichever is applicable, as a psychologist at the time and place services are performed. Where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Residential substance use disorder treatment program, approved substance use disorder treatment program

A program that provides medical and other services specifically for people who are physiologically or psychologically dependent upon or abusing alcohol or drugs. Residential substance use disorder programs must be administered in a licensed facility that operates 24 hours a day, seven days a week. An approved residential program meets all state licensure requirements and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Routine service

A procedure or test ordered for you without direct relationship to the diagnosis or treatment of a specific disease or injury.

Semiprivate room

A hospital room with two beds.

Services

Surgery, care, treatment, supplies, devices, drugs and equipment given by a medical provider to diagnose or treat disease, injury, condition or pregnancy, and which are based on valid medical need according to accepted standards of medical practice.

Skilled nursing facility, approved skilled nursing facility

A facility that provides convalescent and short- or long-term care for illness with continuous nursing and other medical care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. An approved facility is accredited by the Joint Commission on Accreditation of Hospitals and is recognized as an extended-care facility by the Secretary of Health and Human Services of the United States, has entered into a written agreement as a provider by Blue Cross Blue Shield of Michigan and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Special care unit

A designated care unit within a hospital such as a cardiac care, burn care or intensive care unit that contains all necessary types of equipment, together with skilled nursing and support services needed for care of critically ill patients and is recognized as such by Blue Cross Blue Shield of Michigan.

Specialty drugs

Prescription medications used to treat complex conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling, such as refrigeration during shipping, and administration, such as injection or infusion.

Substance use disorder

Taking alcohol or other drugs in amounts that can:

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

TRICARE

A healthcare program of the United States Department of Defense Military Health System.

TruHearing provider

A hearing care provider selected by TruHearing to provide routine hearing care services and hearing aids through an arrangement between Blue Cross and TruHearing. TruHearing is an independent company that provides hearing care services. TruHearing does not provide Blue Cross branded products and services.

Urgently needed care

Care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Virtual care

Care provided by a provider through electronic forms of communication.

Blue Cross
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