Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

State of Michigan

Your Benefit Guide

State Health Plan PPO

Medical and Behavioral Health/Substance Use Disorder Benefits for Medicare Supplemental Members

January 1, 2024

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Welcome

Welcome to the State Health Plan PPO (SHP PPO), a self-insured benefit plan administered by Blue Cross under the direction of the Michigan Civil Service Commission (MCSC). To be eligible for coverage under the SHP PPO, you must reside in the U.S. or its territories. Additional information on eligibility can be found on page 4 of this booklet.

MCSC is responsible for implementing these benefits and any future benefit changes. Blue Cross provides certain services on behalf on MCSC through an administrative-service-only contract. Your benefits are administered by Blue Cross but will be paid using funds from MCSC.

Blue Cross is committed to providing you with excellent value and quality service and we want you to understand your health coverage. With this in mind, we have designed this booklet as an easy-to-read guide to your benefits. Please read through it to get an understanding of which health care services are covered and when you are responsible for out-of-pocket costs.

You can access this book as well as other State Health Plan PPO materials online anytime at **http://www.bcbsm.com/som**.

Contact information

You can call or write the Blue Cross Customer Service Center when you have questions about your benefits and claims.

Blue Cross Blue Shield of Michigan

To help us serve you better, here are a few things to remember.

- Have your Blue Cross ID card handy so you can provide your enrollee and group numbers.
- To ask about a medical or hearing claim, provide the following:
  - Enrollee's name
  - Enrollee's ID number
  - Member's name
  - Provider's name
  - Date the patient was treated
  - Charge for the service
- When writing to us, include copies (not originals) of your bills, any correspondence you may have received from us and other relevant documents. Keep your original bills and documents for your files.
- Include your daytime telephone number on all your letters.

This document is not a contract. Rather, it is intended to be a summary of your SHP PPO benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the official coverage documents, the terms and conditions in those documents will prevail.

Calling

We're available by phone Monday through Friday from 7 a.m. to 7 p.m. We are closed on holidays.

Customer Service (for all claim and benefit questions) **1-800-843-4876**

Behavioral health and substance use disorder services **1-866-503-3158**

Anti-fraud hotline. **1-800-482-3787**

Hearing-impaired customers ..... **TTY 711**

Human organ transplant program **1-800-242-3504**

Blue Cross' network of Blue plan providers ..... **1-800-810-BLUE-(2583)**

Writing

Please send all correspondence to:

State of Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
232 S. Capitol Avenue, L04A
Lansing, MI 48933-1504

Online

bcbsm.com/som — Blue Cross' site for State of Michigan retirees
For benefit materials, the State of Michigan claim form and disabled dependent application

bcbsm.com/find-a-doctor — Blue Cross' provider search tool
To find a participating health care provider or facility

State of Michigan

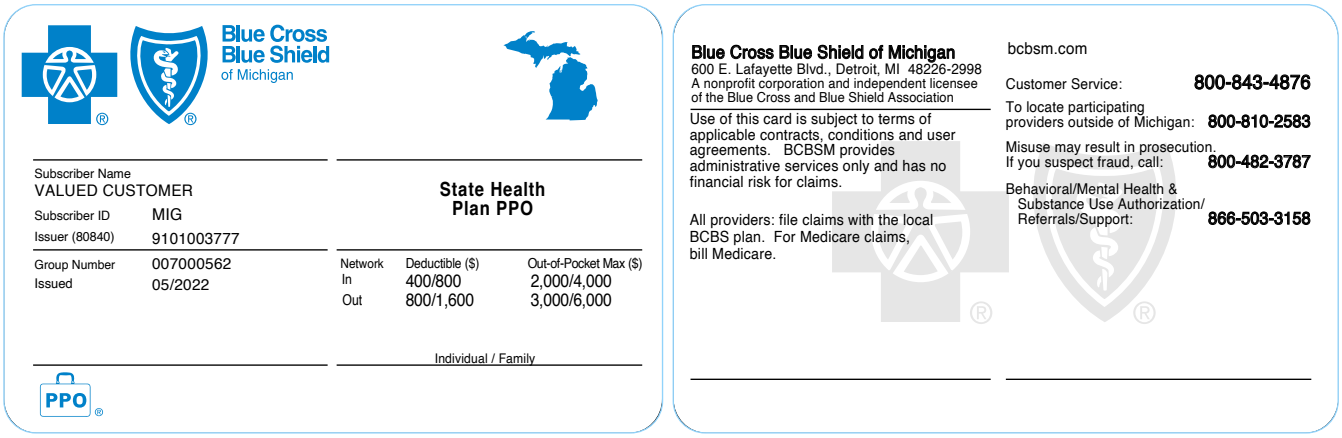
For eligibility questions:
Michigan Department of Technology, Management and Budget
Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671
Local: 517-284-4400
Toll-free: 1-800-381-5111

For benefit questions:

Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909
Toll free: 1-800-505-5011

Your ID card

Your Blue Cross ID card is issued once you enroll for coverage in the SHP PPO. This ID card is applicable for your medical and behavioral health/substance use disorder benefits. Present this ID card every time you need services. Your card will look like the one below.



1st line: **Subscriber Name** is the name of the person who holds the contract. All communications are addressed to this name. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members.

2nd line: **Subscriber ID** identifies your records in our files.

The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through the SHP PPO.

3rd line: **Issuer** identifies you as a Blue Cross member. The number 80840 identifies our industry as a health insurance carrier.

4th line: **Group Number** tells us you are a Blue Cross group member through the State of Michigan.

Note: This sample ID card includes the individual and family in-network and out-of-network deductible and out-of-pocket maximum amounts.

On the back of your ID card, you will find:

- Blue Cross's toll-free customer service telephone numbers to call us when you have a claim or benefit question, or when you need a behavioral health/substance use disorder authorization or referral.

If you or anyone in your family needs an ID card, log in to your account at **bcbsm.com** or call our Customer Service Center for assistance.

- If your card is lost or stolen, call us. You can still receive services by giving the provider your Enrollee ID number to verify your coverage while your new set of cards is on its way.
- You can also log in to your account at **bcbsm.com** to access your virtual ID card. This is a great way to show your coverage to a provider using your mobile phone.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Eligibility

To be eligible for coverage under the SHP PPO, you must reside in the U.S. or its territories. To keep your SHP PPO coverage when you are Medicare eligible, you must enroll in Medicare Parts A and B, and notify the Office of Retirement Services (ORS) that you have other primary coverage. If you have other primary coverage due to active employment or a working spouse, you are eligible to remain in the State's Medicare Supplemental plan. You must provide the ORS the completed Medicare Advantage Opt Out form that was mailed to you and valid proof of other primary coverage. Send proof of coverage to:

Mail: **Michigan Department of Technology, Management and Budget**
Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

Fax: 517-248-4416

Examples of proof include a photocopy of your ID card, a letter from the other carrier, or an open enrollment confirmation.

If you are not enrolled in Medicare Parts A and B and you did not provide proof of other primary coverage, you are not eligible to remain in the State's Medicare Supplemental plan or the prescription drug plan.

For more information about the State of Michigan's eligibility requirements for retiree health insurance coverage, visit **www.michigan.gov/ors**.

In the event you lose your coverage

You can purchase an individual plan from Blue Cross Blue Shield of Michigan, or coverage from the Health Insurance Marketplace. If you'd like information about which individual plan is best for you, contact a Blue Cross Blue Shield Health Plan Advisor at 1-855-237-3500 or visit **bcbsm.com/stayblue**.

For more information on plans on the Health Insurance Marketplace, visit **healthcare.gov**.

Explanation of cost-share

For most covered services, you are required to pay a portion of the approved amount through deductibles, coinsurance and copayments.

Deductibles

Your deductible is the specified amount you pay during each calendar year for services before your plan begins to pay. Deductible amounts are determined by whether you receive services in-network or out-of-network. The in-network deductible is lower than the out-of-network deductible.

The deductible is considered an embedded structure. An embedded structure means that one member cannot meet the full family deductible. Additionally, this means one individual member cannot contribute in excess of the individual deductible toward the family deductible. In the case of two or more members in a family contract, the deductible paid by all members will be combined to satisfy the family deductible.

Certain medical benefits can be rendered before your deductible is fulfilled. For example, there is no deductible for in-network office visits, office consultations, urgent care visits, osteopathic and chiropractic spinal manipulations, medical eye exams and medical hearing exams.

Certain behavioral health and substance use disorder benefits can also be rendered before your deductible is fulfilled. For example, emergency room services and some telehealth visits.

For details on the services that do or do not require fulfillment, please refer to the benefit summary chart or benefit explanation in this booklet.

Coinsurance

After you have met your deductible, you are responsible for a percentage of the Blue Cross allowed amount that is determined by whether you receive services in network or out of network. Coinsurance is not the same as your deductible.

Copayments

Copayment is a fixed dollar amount that you pay at the time of a health care service such as an in-network office visit.

Dollar maximums

Covered services are limited to a lifetime dollar maximum of $5 million per member. This does not include human organ transplants, which have a separate dollar maximum. The dollar maximum for human organ transplants is $1 million per transplant.

Out-of-pocket maximum

The out-of-pocket maximum (OOPM) is the dollar amount you pay in deductible, copayment, and coinsurance during the calendar year. Once you satisfy your OOPM the SHP PPO will cover 100% of the allowed amount for covered services including coinsurances for behavioral health, substance use disorder and prescription drug copays under the State Prescription Drug plan. Certain coinsurance, deductible and other charges cannot be used to meet your OOPM. The changes that cannot be used to meet your OOPM are listed below:

- Out-of-network coinsurance
- Out-of-network deductible
- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other Blue Cross coverage

The OOPM is considered an embedded structure. An embedded structure means that one member cannot meet the family OOPM. Additionally, this means one individual member cannot contribute in excess of the individual OOPM toward the family OOPM. In the case of two or more members, the OOPM paid by all members will be combined to satisfy the family OOPM.

State Health Plan PPO
Medical Benefits

Your medical benefits, A-Z

When you or your covered dependents become eligible for Medicare, your health insurance continues through your Medicare Supplemental benefits with the State Health Plan PPO if you opted out of Medicare Advantage and provided proof to ORS of other primary coverage. These benefits work hand-in-hand with Original Medicare so that you enjoy the same covered services as non-Medicare members.

Although you have PPO benefits through the State Health Plan PPO, Medicare (your primary insurance) requires that you obtain care from Medicare-affiliated providers for services covered by Original Medicare. To reduce your out of pocket costs, you must seek services from a Blue Cross participating provider for those benefits not covered by Original Medicare.

Acupuncture	**Covered – 80% after deductible (No network required)**

Covered up to a maximum of 20 visits in a calendar year when performed by an acupuncturist or a licensed physician (MD or DO), or supervised and billed by a licensed physician (MD or DO).

Acupuncture is covered only for the treatment of the following conditions:

- Sciatica
- Neuritis
- Postherpetic neuralgia
- Tic douloureux
- Chronic headaches such as migraines
- Osteoarthritis
- Rheumatoid arthritis
- Myofascial complaints such as neck and lower back pain

Note: Services received by a non-participating acupuncturist are not covered.

Allergy tests and treatments	**Covered – 90% after deductible**

Allergy testing, including survey and therapeutic injections, are covered when performed by or under the supervision of a physician. Coverage also includes:

- Allergy extract and extract injections
- Intradermal, scratch and puncture tests
- Patch and photo tests
- Bronchial challenge tests

Benefits are not payable for:

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

Ambulance services	Covered – 90% after deductible

You are covered for ambulance services to transport a patient to the nearest medical facility capable of treating the patient's condition.

To be covered, the services must be:

- Medically necessary because transport by any other means would endanger the patient's health
- Prescribed by a physician (when used for transferring a patient)
- Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation
- Used to transport only the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility or the patient's home

Air or water ambulance is also covered if it meets the criteria above and the patient's emergent condition requires air or water transport rather than ground ambulance. Air or water ambulance providers must be licensed to provide air or water ambulance services and **not** as a commercial air carrier.

Your coverage does not pay for transportation for the convenience of the patient, the patient's family or the preference of the physician.

Ambulatory surgery facility	Covered – 90% after deductible

Coverage is provided for medically necessary facility services provided by a Blue Cross participating ambulatory surgery facility. A patient must be under the care of a licensed Doctor of Medicine, osteopathy, podiatry or oral surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by Blue Cross as covered ambulatory surgery.

Anesthesia	Covered – 90% after deductible

Medically necessary anesthesia services are a covered benefit under the State's medical plan regardless if the diagnosis is medical or behavioral health. Anesthesia services for Electro-Convulsive Therapy (ECT) is covered under the State's behavioral health and substance use disorder plan.

Bariatric surgery	Covered – 90% after deductible

Bariatric surgery is covered when you meet certain conditions related to morbid obesity.

Blood	Covered – 90% after deductible

Coverage includes whole blood, blood derivatives, blood plasma or packed red blood cells and supplies used for administering the services, as well as the cost of drawing and storing self-donated blood intended for scheduled surgery.

Breast reconstruction surgery	Covered – 90% after deductible

Surgery is covered for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

Cardiac rehabilitation (Phase I and Phase 2)	**Covered – 90% after deductible**

Coverage provides intensive monitoring (using EKGs) and/or supervision during exercise in the outpatient department of hospital or physician-directed facility.

Cataract surgery	**Covered – 90% after deductible**

Cataract surgery and first lens implants are covered.

Chelation therapy	**Covered – 90% after deductible**

Chelation therapy is used as a treatment for acute mercury, iron, arsenic, lead, uranium, plutonium and other forms of toxic metal poisoning.

Chemotherapy	**Covered – 90% after deductible**

Your benefits for chemotherapy are payable in a hospital, outpatient department of a hospital, or in a physician's office. Benefits include the administration and cost of chemotherapy drugs when they are:

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

You are also covered for:

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

Benefits also include three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

Chiropractic mechanical traction and massage therapy	**Covered – 90% after deductible**

Chiropractic mechanical traction as well as massage therapy are included with physical, occupational and speech therapy for a combined maximum of 90 visits. Massage therapy is only payable as part of the overall physical therapy treatment plan. Massage therapy alone, either as a one-time service or as a series of massages over time is not a covered benefit. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy.

Chiropractic office visits	Covered – Up to $20 copay

Coverage includes office visits for:

- New patient: 1 visit every 36 months
- Established patient: 1 visit per calendar year

Chiropractic spinal manipulation	Covered – Up to $20 copay

Coverage includes spinal manipulation of the spine if medically necessary to correct a subluxation. 24 visits per calendar year. Note: Maintenance therapy is not a covered benefit.

Chiropractic X-rays	Covered – 90% after deductible

Covered for accidental injuries.

Clinic Visits – Facility Services	Covered – 100%

Your benefit covers visits when rendered in a clinic setting for the medically necessary diagnosis or treatment of an injury or sickness.

Clinic Visits – Physician Services	Covered – 90% after deductible

Your benefit covers visits when rendered in a clinic setting for the medically necessary diagnosis or treatment of an injury or sickness. Additionally, your benefit covers clinic visits for behavioral health diagnoses rendered by your primary care physician.

Note: Clinic visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Clinic visits rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Consultations – hospital	Covered – 90% after deductible

Medical consultations are payable when a physician requires assistance in diagnosing or treating a medical condition.

What is not covered

Consultations and/or pre-anesthesia evaluations are not payable when billed with one of the following diagnostic conditions:

- Experimental
- Obesity
- Research
- Routine
- Routine foot care
- Screening
- Psychological
- Staff consultations required by a facility's or program's rules

Note: Hospital outpatient consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Hospital outpatient consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Consultations – office	Covered – Up to $20 copay

In a physicians' office setting, services are covered when they are performed by a physician whose advice or opinion is requested by another physician or other appropriate source for further evaluation of the patient and generally includes exam of patient, patient's record and written report.

Note: Office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Office consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Consultations – pre-surgical	Covered – 90% after deductible

When your physician recommends surgery, you have the option of having a pre-surgical consultation with another physician who is a Doctor of Medicine, osteopathy, podiatry or an oral surgeon.

You may obtain pre-surgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under the SHP PPO.

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

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

Cosmetic surgery	Covered – 90% after deductible

Cosmetic surgery is payable only for:

- Correction of deformities present at birth. Congenital deformities of the teeth are not covered
- Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
- Conditions caused by accidental injuries
- Traumatic scars

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

Dental surgery	Covered – 90% after deductible

Dental surgery performed on an inpatient basis is covered if a patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. Surgery must be performed by an MD or DO. Dental procedures performed by a DDS must be billed to the dental program.

Dental surgery is payable **only** for:

- Multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition
- Surgery directly to the temporomandibular joint (jaw joint)
- Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction

Dental treatment (accidental dental – emergency only)	Covered – 90% after deductible

Accidental dental services are covered to provide relief of pain and discomfort following an injury, as well as repair of those injuries. These services must be completed within six months of the initial injury to be payable under the SHP PPO. An accidental injury is defined as an external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) or bone. Injury as a result of chewing or biting is not considered an accidental injury.

Emergency dental treatments must be completed within 24 hours following the trauma to relieve the patient of pain and discomfort.

Determination of refractive state	Covered – 90% after deductible

Determination of refractive state is necessary for obtaining glasses and is covered under these circumstances:

- A provider must identify your refractive state to determine an injury, illness or disease
- An ophthalmologist or an optometrist must determine the refractive date for corrective lenses
- Your refractive state is determined as part of a surgical procedure

Diabetic supplies	Covered – 100%

The SHP PPO covers blood sugar testing monitors, blood sugar and urine test strips, lancet devices and lancets, blood sugar control solutions, and diabetic therapeutic shoes.

Diabetic training	Covered – 90% after deductible

Self-management diabetic training is considered medically necessary depending on diagnosis by an MD or DO who is managing your diabetic condition. Medical necessity may be a significant change with long-term implications in the symptoms or conditions that necessitate changes in self-management. Medical necessity can also be a significant change in medical protocol or treatment.

Diabetes self-management training may be conducted in a group setting, if practicable. The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

Diagnostic tests and radiation services	Covered – 90% after deductible

Coverage includes physician services for diagnostic and radiation services to diagnose and treat disease, illness, pregnancy or injury through:

- Diagnostic radiology that includes X-rays, ultrasound, radioactive isotopes, and MRI and CAT scans of the head and body when performed for an eligible diagnosis
- Laboratory and pathology tests
- Diagnostic tests which include EKGs, EEGs, EMGs, thyroid function tests, nerve conduction and pulmonary function studies
- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- Medically necessary mammography
- Position emission tomography (PET) scans

Services must be provided by your physician or by another physician, if prescribed by your physician.

Note: All medically necessary diagnostic services are covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Dialysis services – facility	Covered – 90% after deductible

Coverage includes medically necessary services provided to treat patients with chronic, irreversible kidney disease are payable.

The following services are covered:

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment

Dialysis services – home	Covered – 90% after deductible

Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital or freestanding End Stage Renal Disease facility participating with Blue Cross and must meet the following conditions:

- The treatment must be arranged by the patient's attending physician and the physician director or a committee of staff physicians of a self-dialysis training program.
- The owner of the patient's home must give the hospital prior written permission to install the equipment.

Covered services:

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

What is not covered

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

Durable medical equipment; prosthetic and orthotic, and medical supplies	Covered – 100%

Coverage includes items like oxygen, CPAP and related respiratory equipment and supplies, ostomy supplies, and parenteral and enteral nutrition therapy, wheelchairs, walkers, canes, crutches and hospital beds ordered by a doctor or other health care provider for use in the home. Some items must be rented.

Emergency care	Covered – $50 copay (waived if admitted as inpatient)

Your benefit plan covers the sudden and unexpected condition that threatens life or could result in serious bodily harm if prompt medical attention is not received. The patient's condition must be such that failure to obtain care or treatment could reasonably result in significant impairment to bodily functions, permanent health condition is placed in jeopardy, or condition could result in death. Initial examination must occur within 48 hours of the injury or 72 hours of the medical emergency.

Copayment is waived only if the patient is admitted as inpatient. Observation care is not considered an inpatient admission. For more information on how observation care is covered, please go to the Observation care benefit.

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by Blue Cross to be medical emergencies.

What is not covered

- Follow-up care
- Chronic conditions unless an acute, life-threatening attack occurs
- Care and treatment once you are stabilized
- Continuation of care beyond that needed to evaluate or stabilize your condition in an emergency department

Note: Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

End Stage Renal Disease (ESRD)	See "Dialysis services" for additional benefit information.

ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. You may become entitled to Medicare based on ESRD. Benefits on the basis on ESRD are for all covered services, not only those related to the kidney failure condition. Eligible individuals should contact Social Security to enroll in Medicare.

Medicare is the secondary payer to the State Health Plan for individuals entitled to Medicare solely based on ESRD for a coordination period of 30 months. After the 30-month coordination period ends, the State Health Plan is secondary, and Medicare is your primary plan.

Dual entitlement

If you have dual entitlement to Medicare **and** have the SHP PPO benefits, the following conditions apply:

- If you first become eligible to enroll in Medicare because of ESRD and subsequently also become entitled to Medicare because of Disability or Age, the ESRD guidelines continues to apply. The State Health Plan is primary through the end of the 30-month coordination period. At the end of the 30-month coordination period, Medicare becomes the primary payer of benefits, even if Medicare would otherwise be secondary under the Working Aged or Disability guidelines.
- If you are entitled to Medicare based on ESRD and entitled based on Working Aged or Disability, the following Medicare guidelines apply:
  - If you are a Working Aged or a Disabled individual in your first month of dual entitlement, the State Health Plan is primary through the end of the 30-month coordination period. At the end of the 30-month coordination period, Medicare becomes the primary payer of benefits.
  - If you are already entitled to Medicare based on age or disability and you are not actively working in the first month of dual entitlement, Medicare is your primary plan.

Foot care	Covered – 90% after deductible

Certain services to the foot and ankle are covered. This includes cutting or removal of corns, calluses or trimming of nails or application of skin areas, and other hygienic and preventive maintenance care when related to diabetes or peripheral heart disease.

Hearing care

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing problems. Hearing benefits are covered only when services are received from a participating provider and are payable once every 36-months, unless significant hearing loss occurs earlier and is certified by your physician. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

All out-of-state providers are paid the amount that is approved by the local Blue Cross Blue Shield Plan.

Hearing care: Audiometric examination	Participating provider – Covered 100%

Audiometric examinations must be performed by a participating physician-specialist, audiologist, or hearing aid dealer. Covered services include tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination and providing a summary of findings.

Hearing care: Hearing aid evaluation and conformity test	Participating provider – Covered 100%

Evaluation and test must be prescribed by a physician and performed by a participating physician-specialist, audiologist, or hearing aid dealer.

Hearing care: Hearing aids	Covered 100% for standard and binaural aids

Hearing benefits are payable once every 36 months, unless significant hearing loss occurs earlier and is certified by your physician. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time. Coverage includes payment for standard or binaural hearing aids. Deluxe hearing aids are covered up to the amount paid for standard hearing aids. You are liable for the balance of the cost.

Note: Hearing aids are covered up to $2,600 for services provided in or out of network.

Hearing care: Medical hearing clearance exam	Covered – Up to $20 copay

You are covered for exams to evaluate sensory neural and conductive hearing losses. Services must be provided prior to receiving hearing aids. Exams may include a basic hearing screening, which is a brief evaluation done during a routine office visit.

For members over age 17, the exam is only required on the initial hearing aid purchase.

Hearing care: Ordering and fitting of the hearing aid	Participating provider – Covered 100%

Includes basic hearing aids in-the-ear, behind-the-ear, and worn on the body with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid.

Your hearing care coverage does not cover:

- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Additional charges for unusual or cosmetic equipment such as canal, one half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount Blue Cross pays for a basic hearing aid
- All hearing care services and supplies provided by a nonparticipating provider, except for hearing aids which are covered.

  Note: Hearing aids provided by a nonparticipating provider are not covered for State Police who retired on or after 10/1/1987.
- Medical clearance examination to determine possible loss of hearing (covered under medical benefit)
- Repairs and replacement of parts including batteries and ear molds
- Replacement of hearing aids that is lost or broken, unless this occurs after 36 months, when benefits are renewed
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- Charges for audiometric examinations, hearing aid evaluation tests, conformity tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids

Hemophilia	Covered – 90% after deductible

Your benefit covers human antihemophilic factor to reduce the incidence of bleeding episodes and resultant joint damage for individuals who have severe hemophilia A or B.

Home health care	Covered – 90% after deductible (Nonparticipating provider – Not covered)

Your home health care benefit covers services when the service is prescribed by an attending physician and provided and billed by a participating home health care agency. The physician must certify that the home health care services are being used instead of inpatient hospital care, and that the patient is confined to the home due to illness. This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be difficult due to the nature or degree of the illness.

Covered services include:

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, speech and language pathology services and occupational therapy are payable when provided for rehabilitation

If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered, and are subject to the physical, speech and occupational therapy 90-visit maximum.

The following covered services are payable when the home health care is provided by a participating hospital:

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

Your home health care coverage does not cover:

- Custodial care, non-skilled care rest therapy and care in nursing or rest home facilities
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- General housekeeping services
- Transportation to or from a hospital or other facility

Home infusion therapy (HIT)	**Participating provider – Covered 90% after deductible**

Home infusion therapy services are covered whether or not you are confined to the home. To be eligible for home infusion therapy services, your condition must be such that home infusion therapy is:

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if it can be safely managed in the home
- Medically necessary
- Given by participating HIT providers

Services include:

- Drugs required for HIT
- Nursing services needed to administer HIT and treat home infusion therapy-related wound care

  Note: Nursing services must meet Blue Cross's medical necessity guidelines to be payable.
- Durable medical equipment, medical supplies and solutions needed for home infusion therapy

Note: Except for chemotherapeutic drugs, HIT is only covered under the home health care benefit.

Home visits	**Covered – 90% after deductible**

Home visits by a physician are covered.

Hospice care	**Blue Cross or Medicare-certified hospice program – Covered 100% (Nonparticipating provider – Not covered)**

Hospice services are health care services provided to a member who is terminally ill. Services must be provided by a participating hospice program. While regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used, benefits for conditions unrelated to the terminal illness remain in effect. Hospice services include meetings with the hospice staff for a maximum of 28 visits for preadmission counseling, evaluation, education and support services. Hospice services also include routine home care.

Hospital services

- Inpatient care provided by a:
  - Participating hospice inpatient unit
  - Participating hospital contracting with the hospice program or
  - Skilled nursing facility contracting with the hospice program
- Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)
- Five days of occasional respite care during a 30-day period
- Physician services by a member of the hospice interdisciplinary team
- Nursing care provided by, or under the supervision of, a registered nurse
- Medical social services by a licensed social worker, provided under the direction of a physician
- Counseling services to the patient and to caregivers, when care is provided at home
- Blue Cross-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)
- Blue Cross-approved durable medical equipment furnished by the hospice program for use in the patient's home
- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

Physician services

Services provided by the attending physician (not part of the hospice team) to make the patient comfortable and to manage the terminal illness and related conditions.

Hospice care is limited to a maximum amount that is reviewed and adjusted periodically. Please call the Blue Cross State of Michigan Service Center for information about the current maximum amount.

Your hospice services coverage does not cover:

- Costs of transportation
- Estate planning
- Financial or legal counseling
- Funeral arrangements
- Pastoral counseling

Hospice respite care	**Blue Cross or Medicare-certified hospice program – Covered 100%**

Your coverage includes a short-term relief for in-home hospice caregivers. Your benefits pay for patient transport and up to five consecutive days of inpatient care at a Medicare-approved nursing facility or hospital. You can get respite care more than once, but only on an occasional basis.

Hospital care – inpatient	**Covered – 90% after deductible**

Your coverage includes the following inpatient hospital services when medically necessary:

- Semi-private room and board, general nursing services and special diets
- Services provided in a special care unit, such as intensive care
- Inpatient rehabilitation

- Physician services
- Unlimited general medical care days
- Anesthesia, laboratory, oxygen, radiology and pathology services, drugs, durable medical equipment, medical and surgical supplies, prosthetic and orthotic appliances
- Chemotherapy, inhalation therapy and hemodialysis
- Diagnostic and radiology services
- Maternity care, and routine nursery care for a newborn during an eligible mother's hospital stay
- Operating and other surgical treatment rooms, delivery room and special care units
- Physical, speech and occupational therapy (Note: Not subject to the 90-visit benefit maximum)
- Pain management
- Cardiac rehabilitation services
- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
- Hyperbaric oxygenation (therapy given in a pressure chamber)
- Organ transplants
- Other inpatient services and supplies necessary for treatment

Hospital care – outpatient	**Covered – 90% after deductible**

The services listed under "Hospital care – inpatient" are also payable when provided as outpatient care when performed in the outpatient department of a hospital or, where noted, in a freestanding facility approved by Blue Cross. See the individual benefit listing for details.

Hospital care – outpatient office visits	**Covered – Up to $20 copay**

Your benefit covers office visits when rendered in an outpatient setting outside of the main hospital campus (e.g., physician practices owned by the hospital) as well as inside the main hospital campus for the medically necessary diagnosis or treatment of an injury or sickness. Outpatient office visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Outpatient office visits rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Human organ transplants **Call HOTP at 1-800-242-3504 for more information**

Human organ transplants and bone marrow	**Covered – 100% when pre-approved (Designated facilities)**

Specified human organ transplants are covered when performed in a designated facility. All services must be pre-certified. We cover transplantation of the following organs:

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung
- Lung(s)

- Pancreas
- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by Blue Cross)

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

When directly related to the transplant, we cover:

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

    Note: We will cover any service needed to treat a condition as a **direct** result of the organ transplant surgery as long as it is a benefit under any of our certificates.

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

- Allogeneic transplants are covered for the following services:
  - Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is pre-approved
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
    - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
    - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for sickle cell anemia or beta thalassemia.)
    - Harvesting and storage are covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a Blue Cross member. In a case of sickle cell anemia or beta thalassemia, the donor must be an HLA-identical sibling
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Travel and Lodging:

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

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

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

Note: These daily allowances may be adjusted from time to time. Please call Blue Cross Customer Service to find out the current maximums.

We also cover the following:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery. This includes the cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor). Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization are not covered

  Note: In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the $10,000 maximum for travel and lodging.
- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)

Cost of acquiring the organ (the organ recipient must be a Blue Cross member. This includes, but is not limited to:

  - Surgery to obtain the organ
  - Storage of the organ. Storage of donor organs for the purpose of future transplants is not covered.
  - Transportation of the organ
  - Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
  - Payment for covered services for a donor if the donor does not have transplant services under any health care plan

Human organ transplants – cornea and kidney	**Covered – 90% after deductible**

The SHP PPO covers human organ and tissue transplants such as cornea and kidney when they are received at a participating hospital or designated cancer center. All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, are payable during the first 24 months post-transplant.

What is not covered

- Post-transplant immunizations for cornea are not covered.

Human organ transplant - skin	**Covered – 90% after deductible**

The SHP PPO covers human organ and tissue transplants such as skin when received at a participating hospital or designated cancer center. Post-transplant immunizations for skin transplants are not covered.

Injections	**Covered – 90% after deductible**

Fluids that are forced into a vein or body organ or under the skin to fight disease are payable.

Laboratory and pathology (clinical)	**Covered – 90% after deductible**

Coverage includes laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury.

Laboratory and pathology (non-clinical)	**Covered – 90% after deductible**

Coverage includes laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury.

Maternity care

You have coverage for pre- and post-natal services, including services provided by a physician attending the delivery. Maternity care benefits are also payable when provided by a certified nurse midwife.

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

Note: The baby must be eligible for coverage and must be added to your contract within 31 days of the birth.

Prenatal care	**Covered 80% after deductible**
Postnatal care	
Delivery and nursery	

Medical eye exams	**Covered – Up to $20 copay**

Benefit includes the diagnosis and treatment of an illness, injury or disease.

Nutritional & health education and counseling	**Covered – 100%**

The plan covers up to six visits per calendar year. You can seek services from certified dietitians and/or nutritionists.

Observation care	**Covered – 100%**

Your benefit covers hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. Because observation services often involve an overnight stay in the hospital, they may look no different than inpatient services.

Office visits and office consultations	**Covered – Up to $20 copay**

Your benefit covers doctor office visits and doctor office consultations when rendered in an office setting for the medically necessary diagnosis or treatment of an injury or sickness. Additionally, your benefit covers office visits for behavioral health diagnoses rendered by your primary care physician.

Note: Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Office visits and office consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Optical services - post cataract surgery	**Covered – 90% after deductible**

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

Oral surgery	**Covered – 90% after deductible**

Oral surgery is covered with limitations

Orthognathic surgery	**Covered – 90% after deductible**

Orthognathic surgery is covered with limitations.

Osteopathic manipulation	**Covered – Up to $20 copay**

Coverage is provided for osteopathic manipulation.

Physical, occupational, speech, and massage therapy (combined maximum of 90 visits)	**Covered – 90% after deductible**

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for rehabilitation. Therapy must be given for a condition that can be significantly improved in a reasonable and generally predictable period (usually about six months). This includes services rendered in a physician's office and an outpatient facility. Chiropractors may perform massage therapy when provided as part of a complete physical therapy plan. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy. Massage therapy not part of a formal course of treatment is not a covered benefit. Developmental speech therapy for children through 6 years is also covered. (The benefit maximum does not apply for developmental speech therapy).

Note: Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other nonparticipating facility independent of a hospital or an independent sports medicine facility.

Benefit maximum

These services have a combined benefit maximum of 90 visits per member, per calendar year, for services rendered in an outpatient location (hospital outpatient, independent therapist offices, freestanding outpatient physical therapy facility or physician's office) whether obtained from an in-network or out-of-network provider.

Physical, occupational and speech therapy services related to autism treatment are subject to the combined benefit maximum of 90 visits.

Mechanical traction performed by a chiropractor **is** applied toward this maximum.

The physical therapy, speech and language pathology services and occupational therapy benefit maximum renews each calendar year.

Visit count

Each treatment date counts as one visit even if two or more therapies are provided and two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

Physical therapy must be:

- Given by a(n):
  - Doctor of medicine, osteopathy or podiatry
  - Dentist for the oral-facial complex
  - Chiropractor rendering mechanical traction
  - Optometrist for services which he or she is licensed
  - Certified nurse practitioner in an independent practice
  - Physical therapist
  - Physical therapist in a physician's or independent physical therapist's office
  - Independent physical therapist in his or her office
  - Physical therapy assistant and athletic trainer under the direct supervision of a physical therapist
  - Physician assistant or certified nurse practitioner employed by a physician
  - Physical therapy assistant or athletic trainer under the direct supervision of an independent physical therapist in the therapist's office

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Speech and language pathology services must be:

- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

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Occupational therapy must be:

- Given by a(n):
  - Occupational therapist
  - Occupational therapy assistant under the direct supervision of an occupational therapist
  - Athletic trainer under the direct supervision of an occupational therapist

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

What is not covered:

- Health club membership or spa membership
- Massage therapy (Unless it is part of the overall treatment plan)
- Services provided by speech-language pathology assistants or therapy aides
- Congenital or inherited speech abnormalities for members over the age of 6

- Developmental conditions or learning disabilities for members over the age of 6
- Inpatient hospital admissions principally for speech or language therapy
- Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

  Note: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.
- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities for members above the age of 6 years.

  Note: For certain pediatric patients (above the age of six years) with severe retardation of speech development, a Blue Cross medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.
- Therapy to treat long-standing, chronic conditions such as arthritis that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning

Pre-admission testing	**Covered – 90% after deductible**

Testing must be performed within seven days before a scheduled hospital admission or surgery. These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.

Preventive services	**Covered – 100%**

Preventive services may include tests or services recommended by your doctor when they are used to first detect or screen for a disease or condition. Examples of preventive services are those included in annual exams, such as health maintenance exams (physicals) or OB-GYN visits.

For a complete list of preventive services covered under the SHP PPO, visit the benefits tab of the State of Michigan Employees page at: **www.bcbsm.com/som**.

Private duty nursing	**Covered – 90% after deductible (requires prior authorization)**

Covered when the patient's medical condition requires in-home private duty nursing services. Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The State Health Plan does not cover private duty nursing services provided by medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers.

Rural health clinic	**Covered – Up to $20 copay**

Your benefit covers doctor visits when rendered in a rural health clinic setting for the medically necessary diagnosis or treatment of an injury or sickness.

Note: Services rendered at a rural health clinic relating to behavioral health will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Self-Administered Drugs	Covered – 100%

Your benefits provide for self-administered drugs provided in the hospital outpatient setting.

Skilled nursing care	Covered – 90% after deductible (in a Blue Cross-approved skilled nursing facility) (Nonparticipating provider – Not covered)

Your benefits provide for skilled care and related physician services in a skilled nursing facility (SNF). Admission is covered when:

- The admission is ordered by the patient's attending physician
- The patient is suffering from or gradually recovering from an illness or injury and is expected to improve

We require written confirmation of the need for skilled care from the patient's attending physician.

Benefit period

Maximum of up to 120 days per confinement.

Note: Nursing services are covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Nursing service rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

The following services are covered:

- Semiprivate room, general nursing services, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions used while in the SNF
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the SNF or for use outside of the facility when rented or purchased from the facility upon discharge
- Physical therapy, occupational therapy, and speech and language pathology services

Note: PT, OT and ST services must not be the principal reason for an admission or provided in conjunction with a noncovered admission. The physical and occupational therapy or speech-language pathology services that are done in a skilled nursing facility are inpatient benefits. The 90 visit benefit maximums apply only when these services are provided on an outpatient basis.

What is not covered

- Care for long-term mental illness
- Care for senility or mental retardation
- Care for substance use disorder
- Custodial care

Sleep studies	Covered – 90% after deductible

Sleep studies are covered when a patient is referred by a physician to a sleep disorder facility that is affiliated with a hospital and that is under the direction of physicians. Patient must show signs or symptoms of:

- Narcolepsy characterized by abnormal sleep tendencies, amnesia episodes or continuous agonizing drowsiness
- Severe upper airway apnea

Sleep studies are not covered for the following:

- Bruxism
- Drug dependency
- Enuresis
- Hypersomnia
- Impotence
- Night terrors or dream anxiety attacks
- Nocturnal myoclonus
- Restless leg syndrome
- Shift work and schedule disturbances

Specified oncology clinical trials	**Covered – 90% after deductible in designated facilities when pre-approved**

Coverage is provided for a study conducted on a group of patients to determine the effect of a treatment. This includes Phase I, Phase II, Phase III and Phase IV.

This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires these drugs, and the reasonable cost of their administration, be covered. Payment is determined by services provided.

For services to be covered, the following requirements must be met:

- The inpatient admission and length of stay must be medically necessary and pre-approved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center.
- The treatment plan, also called "protocol," must meet the guidelines of the American Society of Clinical Oncology statement for clinical trials.

If these requirements are not met, the services will not be covered and you will be responsible for all charges.

Please call the Blue Cross Customer Service Center for additional information on specified oncology clinical trials.

Surgery	**Covered – 90% after deductible**

Surgery is covered inpatient and outpatient, in the physician's office and in ambulatory surgical facilities.

Multiple surgeries (two or more surgical procedures performed by the same physician during one operative session) are also covered, but are subject to the following payment limitations:

- When surgeries are through **different** incisions, the SHP PPO pays the approved amount for the more costly procedure and one half of the approved amount for the less costly procedure.
- When surgeries are through the **same** incision they are considered related and the SHP PPO pays the approved amount only for the more difficult procedure.

Coverage also includes the administration of anesthesia, performed in connection with a covered service by a physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures.

A technical surgical assistant is covered for certain major surgeries that require surgical assistance by another physician.

What is not covered

- Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- Reverse sterilization

Telehealth - Blue Cross online tool (online visits)	**Covered – $0 copay**

You have access to online health care powered by Virtual Care (formerly Blue Cross Online Visits℠), available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	**Covered – $20 copay**

You have access to online health care using your provider's online tool.

Temporomandibular Joint Syndrome (TMJ)	**Covered – 90% after deductible**

Benefits for TMJ or jaw-joint disorder are limited to:

- Surgery directly to the jaw joint
- X-rays (including MRIs)
- Trigger point injections
- Arthrocentesis (injection procedures)

What is not covered

- Irreversible TMJ services with the exception of surgery directly related to the jaw joint
- Treatment of TMJ and related jaw-joint problems by any method other than as specified in this benefit booklet

Urgent care visits	**Covered – Up to $20 copay**

Non-emergency treatments are covered at independent urgent care facilities.

Weight loss	**Covered – $300 lifetime maximum**

When preauthorized by Blue Cross, benefits are available for non-medical weight reduction up to a lifetime maximum of $300.

Wigs	**Covered – $300 lifetime maximum**

Up to a lifetime maximum of $300 for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs because of cancer or alopecia.

Benefit summary

	In network
Cost share	
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family
Deductible	$400 per member $800 per family
Coinsurance	10% for most services 20% for acupuncture
Fixed dollar copays	Up to $20 copay for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation $0 copay for telehealth (Blue Cross online tool)
Preventive services - Limited to $1500 per calendar year per person (for most services) For a complete list, visit www.bcbsm.com/som/state-of-michigan-retirees.html	
Annual gynecological exam	100%
Annual physical	100%
Adult vaccinations	100%
Mammography	100%
Prostate screening	100%
Emergency medical care	
Ambulance services	90% after deductible
Emergency room (Copay is waived if admitted as inpatient)	Up to $50 copay for Medicare-eligible members $200 copay for Non-Medicare-eligible members
Observation care	100%
Diagnostic tests and radiation services	
Diagnostic mammography	90% after deductible
Diagnostic tests	
Lab and pathology tests	
Position Emission Tomography (PET) scans	
Radiation therapy	
X-rays, ultrasound, MRI and CAT scans	
Hospital care	
Chemotherapy	90% after deductible
Consultations – inpatient and outpatient	
Inpatient care – unlimited days	
Alternatives to hospital care	
Home health care (unlimited visits)	90% after deductible (participating provider only); nonparticipating provider – not covered
Hospice care	100% (participating provider only); nonparticipating provider – not covered
Private duty nursing (requires prior authorization)	90% after deductible

Skilled nursing care (Up to 120 skilled days per confinement)	90% after deductible (nonparticipating provider – not covered)
Urgent care visit	Up to $20 copay
	In-network
Human organ transplants – Contact HOTP at 1-800-242-3504 for additional criteria and information	
Bone marrow	100% in designated facilities when pre-approved
Kidney, cornea and skin	90% after deductible
Liver, heart, lung, pancreas and other specified organs	100% in designated facilities when pre-approved
Surgical services	
Surgery	90% after deductible
Hearing care	
Audiometric exam	100%
Hearing aid evaluation and conformity test	
Hearing aid (ordering and fitting)	
Hearing aids (standard and binaural)[1]	
Medical hearing clearance exam	Up to $20 copay
Other services	
Acupuncture (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)	80% after deductible
Allergy testing and therapy	90% after deductible
Anesthesia	
Cardiac rehabilitation (Phase 1 and Phase 2)	
Chiropractic / spinal manipulation 24 visits per calendar year	Up to $20 copay
Durable medical equipment; prosthetic and orthotic appliances and medical supplies	100%
Injections	90% after deductible
Office consultations	Up to $20 copay
Office and outpatient hospital visit	
Osteopathic manipulation therapy	
Home visits	90% after deductible
Outpatient physical, speech and occupational combined 90 visit maximum per calendar year	
Weight loss	$300 lifetime maximum
Wig, wig stand, adhesives	

[1]*Hearing aids are covered up to $2,600 for services provided in or out of network.*

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the Blue Cross-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

What is not covered

The following general services are not covered under the SHP PPO:

- Care and services received under another certificate offered by Blue Cross or another Blue Cross Blue Shield Plan
- Infertility treatments
- Items for the personal comfort or convenience of the patient
- Medical services or supplies provided or furnished before the effective date of coverage or after the coverage termination date
- Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting
- Premarital or pre-employment exams
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services without cost
- Services that are not included in your plan coverage documents
- Services are not covered for incarcerated members
- Transportation and travel except as specified in this benefit booklet
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund

Selecting providers when using your State Health Plan PPO

When you select hospitals, doctors or other medical providers, always ask if they accept assignment of Medicare claims. This means they will not bill you for the difference between their charge and the Medicare approved amount. These providers will also file your Medicare claims for you. To find out if a particular provider accepts Medicare assignment, check directly with the provider or call 800-MEDICARE. To find a Medicare provider in a particular area, call the local Medicare administrator, or visit **medicare.gov**. You can obtain the number of the local Medicare administrator by calling **1-800-MEDICARE**.

Providers that do not accept Medicare assignment will cost you more and you may have to file claims for supplemental benefits.

TruHearing®

State Health Plan members have access to TruHearing®, a national Blue Cross Blue Shield participating provider.

Your plan covers standard hearing aids at 100 percent of the Blue Cross-approved amount. However, for deluxe hearing aids, you're responsible for the difference between the approved amount and the provider's charge. TruHearing provides exclusive savings of 30 to 50 percent off the retail price of deluxe hearing aids—an average savings of $1,780 per pair.

Combining your hearing aid coverage with TruHearing discounts will help to reduce your out-of-pocket costs.

How it works (For example only)

Sample Models (per pair)	Retail Price	TruHearing Discounted Charge Price	Blue Cross Approved Amount *	You Pay
ReSound Alera 5W	$3,720	$1,790	$2,600	$0
Phonak Audeo Q50	$3,920	$2,190	$2,600	$0
Oticon Nera Pro	$5,900	$3,100	$2,600	$500

This benefit allows you to seek services from an in-network or out-of-network provider and also from non-participating providers (e.g., Costco, Sam's Club, etc.). **If you seek services from a non-participating provider, you must pay for services out of pocket, then complete and submit a member reimbursement form.**

You can find the **Blue Cross Blue Shield of Michigan Member Reimbursement Form** at **www.bcbsm.com/som** under the Forms tab.

For questions about TruHearing, or to schedule an appointment, call TruHearing Customer Care at **1-844-207-1684**. TTY users should call **1-800-975-2674**.

Value-added resources at no cost to you

As a retiree enrolled in the SHP PPO, you and your eligible dependents can participate in several wellness and discount programs. While these programs are designed to improve health and complement traditional health care, some also could save you money. For more information on these value-added programs, visit **bcbsm.com**.

Blue365℠

With Blue365, you can score big savings and special offers on health products and services from both Michigan and national companies just by showing your Blue Cross ID card. This discount savings program is offered through an easy-to-use online tool updated daily for your convenience. Check out **blue365deals.com** to get started.

Blue Cross® Health & Wellness – Online wellness resources

The Blue Cross Health & Wellness website, powered by WebMD®, offers you a variety of resources to help you live a healthier lifestyle. Just log in to your member account on **bcbsm.com**, then click on the *Health & Well-Being* tab to enter to the Blue Cross Health & Well-Being website. There you'll find:

- An interactive, easy-to-complete health assessment that provides you with a list of your health risks and ways to improve your health
- Digital Health Assistant programs for exercise, nutrition, weight loss, stress relief and mental health that help you set goals and make small positive changes
- Blue Cross Blue Shield of Michigan's Tobacco Coaching program powered by WebMD®. It provides you with the support and resources you need to establish and embrace a tobacco-free life
- A Personal Health Record that allows you to track self-reported data such as medical test results, conditions, medications, allergies and more
- A Device & App Connection Center where you can sync your favorite fitness and medical devices and health-specific mobile apps with the website
- Professionally monitored Message Board Exchanges
- Interactive programs such as calculators, guides, quizzes and slide shows
- Videos, recipes, articles, health encyclopedias and more

The Engagement Center

The Engagement Center is a central hub of resources where you can learn more about how to make the most of Blue Cross's services and tools. For example, with the 24-Hour Nurse Line, you can contact our team of nurses with any health-related questions you have. To contact the Engagement Center, call 1-800-775-BLUE from 8 a.m. to 6 p.m. EST Monday through Friday.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and wellness services.

Coordination of benefits

Coordination of benefits (COB) is the process group health care plans and insurance carriers use to manage benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your SHP PPO requires that your benefit payments are coordinated with those from any other group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the group health care plans. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB works

When a patient has double coverage, Blue Cross determines who should pay before processing the claim. If the SHP PPO is primary, then full benefits under the plan will be paid. If the SHP PPO is secondary, payment towards the balance of the cost of covered services — up to the total allowable amount determined by both group plans — will be paid.

These are the guidelines used to determine which plan pays first:

- If a group health plan does not have a coordination of benefits provision, that plan is primary.
- If husband and wife have their own coverage, the husband's health coverage is primary when he receives services and the wife's coverage is primary when she receives services.
- If a child is covered under both the mother's and the father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary. If the child's parents are divorced, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:
  - Custodial parent
  - Custodial stepparent (if the custodial parent has remarried)
  - Noncustodial parent
  - Noncustodial stepparent (if the noncustodial parent has remarried)

If the primary plan cannot be determined by using the guidelines above, then the plan covering the child the longest is primary.

Processing your COB claims

When we receive your claim, we determine which plan is primary. Then we process your claim as follows:

- If the SHP PPO is primary, Blue Cross will pay for covered services up to the maximum amount allowed under your benefit plan, less any deductible or copays.
- If the other health plan is primary, Blue Cross will return the claim to your provider, indicating that the SHP PPO is not primary, so your provider can bill the other group health plan. We will also send you an Explanation of Benefit Payments (EOBP) form that tells you we have billed another carrier.
- If Blue Cross is both primary and secondary, we will process your claim first under the primary plan, and then automatically process the same claim under the secondary plan.
- If Blue Cross is secondary and the primary plan has already paid, either you or your provider can submit a claim to us for consideration of any balances.

Be sure to include the EOB form you received from your primary plan. **Please make copies of all forms and receipts for your files.**

Keeping your COB information updated

After enrollment, we will periodically send you a COB questionnaire to update your coverage information. Please complete and return this questionnaire so we can continue processing your claims without delay.

Subrogation

Occasionally, another person, insurance company or organization may be legally obligated to pay for health care services that we have paid. When this happens:

- Your right to recover payment from them is transferred to Blue Cross.
- You are required to do whatever is necessary to help Blue Cross enforce their right of recovery.

If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse Blue Cross. However, this does not apply if the funds you receive are from additional health coverage you purchased in your name from another insurance company.

Auto No-Fault Insurance

Beginning July 2, 2020, the State's Automobile No Fault Insurance Law changed. Under the new legislation, eligible members may select different levels of PIP coverage in certain circumstances. These changes apply to policies issued or renewed after July 1, 2020.

Personal Injury Protection (PIP) pays for services that health insurance may or may not pay for such as:

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

Your Blue Cross coverage does not change because of this legislation. However, the way your auto insurance coverage coordinates with your health benefits could change depending on what level of PIP coverage you choose. Contact your auto insurance carrier/agent for specific questions regarding PIP coverage.

Explanation of benefits

You will receive an *Explanation of Benefits* (EOB) form every month we process a claim under your contract number. The EOB is not a bill. It is a statement that helps you understand how your benefits were paid. It tells you:

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a network or participating provider
- Helpful information about Blue Cross programs
- Service dates, charges, payments and any balance you may owe

You may access your EOB forms online by visiting **bcbsm.com** and signing in at the Members Secured Services site. You may also receive your EOBs by mail.

Please check your EOBs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the Blue Cross Customer Service Center.

If you think your provider is intentionally billing us for services you did not receive, or that someone is using your Blue Cross ID card illegally, contact our anti-fraud toll-free hotline at 800-482-3787. Your call will be kept strictly confidential.

Filing claims

When you use your benefits, a claim must be filed before payment can be made. PPO network providers and Blue Cross participating providers should automatically file all claims for you. All you need to do is show your Blue Cross ID card. However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

- Ask your provider for an itemized statement with the following information:
  - Patient's name and birth date
  - Enrollee's name, address, phone number and enrollee number (from your Blue Cross ID card)
  - Provider's name, address, phone number and federal tax ID number
  - Date and description of services
  - Diagnosis (nature of illness or injury) and procedure code
  - Admission and discharge dates for hospitalization
  - Charge for each service
- Make a copy of all items for your files. You will also need to complete a claim form. To obtain a form, visit **bcbsm.com/som** or call the Blue Cross Customer Service Center.
- Mail the claim form and itemized statement to the Blue Cross Customer Service Center at:

  Blue Cross Blue Shield of Michigan
  Member Claims
  600 E. Lafayette Blvd., MC0010
  Detroit, MI 48226-2998

You will receive payment directly from Blue Cross. The check will be in the enrollee's name, not the patient's name.

Medicare coverage

The SHP PPO is primary, which means it pays first for actively working employees and their enrolled dependents. Medicare enrollment is not required by the SHP PPO while you are covered under the active employee group coverage. You will want to consult with Medicare to confirm your Medicare enrollment requirements while enrolled in the active retiree group coverage. If you or your dependent is eligible to enroll in Medicare because of End State Renal Disease, the SHP PPO will pay first for 30 months, whether or not you are enrolled in Medicare. During this time, Medicare is the secondary payer. At the end of the 30 months, Medicare becomes the primary payer.

Enrolling in Medicare

Enrollment in Medicare is handled in two ways: 1) you are enrolled automatically, or 2) you must apply.

Here is how it works:

Automatic enrollment for those already receiving Social Security benefits

If you're not 65 yet but receive Social Security, you don't have to apply for Medicare. You'll be automatically enrolled in Medicare Part A and Part B, and it will begin the month you turn 65. Your Medicare card will be mailed to you about three months before your 65th birthday.

If you are disabled and have been receiving disability benefits under Social Security for 24 months, you'll be automatically enrolled in Medicare Part A and Part B beginning the 25th month of your disability benefits. Your card will be mailed to you about three months before your Medicare benefits begin.

If you choose to enroll in Medicare Part A and/or Part B

You can enroll in Medicare during your Initial Enrollment Period (IEP) even if you do not plan to retire at age 65. When you apply through Social Security, there is an option to apply for Medicare only. You can sign up to receive Social Security retirement benefits later.

If you miss your Initial Enrollment Period for whatever reason, you can sign up for Medicare Part A and/or Part B during the General Enrollment Period that runs from January 1 through March 31 of every year, but your coverage will start July 1. You may have to pay a late enrollment penalty for both Part A and Part B if you did not sign up when you first became eligible. You can also make changes to your coverage during general enrollment.

If you sign up for Medicare Part A and/or Part B during your initial enrollment, the start of your coverage will depend on which month of Initial Enrollment Period you signed up. The following chart shows when your Medicare coverage becomes effective if you enroll during your Initial Enrollment Period:

If you enroll in this month of your initial enrollment period:	**Then your Medicare coverage starts:**
One to three months before you turn 65 years old	The month you turn 65 years old
The month of your 65th birthday	One month after your 65th birthday
Two or three months after you turn 65 years old	Three months after you enroll in Medicare

For more information on Medicare's enrollment period log on to the Social Security – Medicare website at **http://www.socialsecurity.gov/pubs/10043.html**.

If you are covered under a group health plan based on current employment, you qualify for a Special Enrollment Period during which you may sign up for Medicare Part A and/or Part B. The Special Enrollment Period provides two options for enrollment:

- You may enroll in Medicare Part A and/or Part B anytime, if you or your spouse (or family member if you are disabled) are working and covered by a group health plan.
- You may enroll during the eight-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.

REMEMBER: Medicare enrollment is not required by the SHP PPO while you are actively working. The SHP PPO is your primary coverage. Upon retirement, if you are Medicare eligible and do not enroll in Medicare Part A and Part B at the appropriate time, you will not be eligible for health and prescription drug insurance under the State of Michigan Employee Retirement System.

For more information on Medicare, log on to the Medicare website at **www.medicare.gov**. For more information on retirement insurance eligibility contact the Office of Retirement Services at 800-381-5111, Monday through Friday, 8:30 a.m. – 5 p.m.

Coordinating Medicare and your supplemental coverage

When you enroll in Medicare, it becomes your primary coverage and will determine if the service rendered is a benefit, and if so, the approved amount for that service. The State Health Plan PPO is your secondary coverage, and provides benefits that may not be covered under Medicare Part A or Part B. In these instances, the State Health Plan PPO becomes your primary coverage, and therefore, it's important to seek services from a Blue Cross Blue Shield participating provider to avoid unnecessary out-of-pocket costs.

For the following services, you need to be sure to see a Blue Cross participating provider:

- Needles with syringes for diabetics
- Surgical stockings (up to eight stockings per year)
- Hearing examination and hearing aid devices
- Private duty nursing
- Annual routine Pap smears (Medicare only pays for one every three years)
- X-rays furnished by a chiropractor
- Preventive exams
- Immunizations
- Hepatitis C screening
- Acupuncture
- Temporomandibular Joint Syndrome
- Rabies treatment
- Wigs
- Weight loss benefit

State Health Plan PPO

Behavioral Health/Substance Use Disorder Benefits

Your Behavioral Health/Substance Use Disorder Benefits, A–Z

When you or your covered dependents become eligible for Medicare, your health insurance continues through your Medicare Supplemental benefits with the State Health Plan PPO if you opted out of Medicare Advantage and provided proof to ORS of other primary coverage . These benefits work hand-in-hand with Original Medicare so that you enjoy the same covered services as non-Medicare members.

Although you have PPO benefits through the State Health Plan PPO, Medicare (your primary insurance) requires that you obtain care from Medicare-affiliated providers.

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions.

Ambulance	**Covered – 90% after deductible**

You are covered for ambulance services to transport you to the nearest medical facility capable of treating your condition for behavioral health or substance use disorders. To be covered, the services must be medically necessary.

Autism spectrum disorders Applied Behavioral Analysis (ABA)	**Covered – 90% after deductible**

You are covered for ABA services administered by a licensed clinician, such as a board-certified behavior analyst, working in association with a paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician. Your benefit covers autism spectrum disorders to treat ABA.

Clinic Visits – Physician Services	**Covered – 90%**

Your benefit covers visits rendered in a clinic setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Clinic visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Consultations – Hospital (Inpatient)	**Covered – 100%**

Medical consultations are payable when a physician requires assistance in diagnosing or treating a condition relating to behavioral health or substance use disorder. Hospital outpatient consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Electroconvulsive Therapy (ECT)	**Covered – 100%**

You are covered for medically necessary ECT treatment including anesthesia services for this benefit. Anesthesia services for ECT is covered at 100% of the allowed amount or billed charges (whichever is less).

Emergency care	**Covered – $50 copay for emergency room (waived if admitted to the same hospital)**

Your benefit plan covers emergency care for behavioral health and substance use disorder diagnoses. Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

Hospital care – Inpatient Behavioral Health	**Covered – 100%**

You are covered for behavioral health care services that require a hospital stay. Your benefit allows for unlimited days.

Hospital care – Inpatient Substance Use Disorder	**Covered – 100%**

You are covered for inpatient substance use disorder services as well as sub-acute detoxification services. Your benefit allows for 28 days per treatment period with a maximum of two treatment periods per plan year with at least 60 days between admissions. If a member relapses soon after discharge a second inpatient may be included as the same treatment period but the combined number of days cannot exceed the 28 day total.

Intensive Outpatient Program (IOP) – Behavioral Health	**Covered – 100%**

You are covered for IOP mental health services provided on an outpatient basis. These services involve frequent visits (usually 3 to 5 days per week) and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Intensive Outpatient Program (IOP) – Substance Use Disorder	**Covered – 100%**

You are covered for IOP substance use disorder services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Neuropsychological testing – inpatient	**Covered – 100%**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Neuropsychological testing – outpatient or office	**Covered – 90%**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Office visits and office consultations	**Covered – 90%**

Your benefit covers office visits and office consultations when rendered in an office setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – Behavioral Health	Covered – 90%

You are covered for individual, conjoint, family or group psychotherapy and crisis intervention services. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – Substance Use Disorder	Covered – 90%

Services include office based opioid treatment and methadone maintenance. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Partial Hospitalization Program (PHP) – Behavioral Health	Covered – 100%

PHP is a comprehensive care given for a minimum of 6 hours per day, 5 days a week. Treatment may include counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. PHP services are often provided in lieu of inpatient behavioral health for non-acute conditions. Two PHP days equal one inpatient day.

Partial Hospitalization Program (PHP) – Substance Use Disorder	Covered – 100%

Program offered at least five hours of therapy a day, up to seven days a week. Two PHP days equal one inpatient day.

Psychological testing – inpatient	In-network – Covered 100%

Your benefit covers medically necessary psychological testing from behavioral health providers.

Psychological testing – outpatient or office	Covered – 90%

Your benefit covers medically necessary psychological testing from behavioral health providers.

Residential Substance Use Disorder treatment	Covered – 100%

Acute care services provided in a structured full day setting when patient is ambulatory and does not require medical hospitalization. Residential services may include 24-hour supervision, counseling, detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Benefit counts toward the 28 days treatment period under inpatient substance use disorder.

Rural health clinic	Covered – 90%

Your benefit covers visits rendered at a rural health clinic relating to behavioral health. Services rendered at a rural health clinic relating to a medical are covered under the State's medical plan.

Telehealth - Blue Cross online tool (online visits)	Covered – $0 copay

You have access to online health care powered by Virtual Care (formerly Blue Cross Online Visits℠), available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	Covered – $20 copay

You have access to online health care using your provider's online tool.

Benefit summary

	In network
Cost share	
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family
Deductible	$400 per member $800 per family
Coinsurance	10% (where applicable)
Copays	Up to $20 copay for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation $0 copay for telehealth (Blue Cross online tool)
Emergency Care	
Ambulance – medically necessary ambulance charges	90% after deductible
Emergency room	$50 copay
Hospital care (Inpatient)	
Hospital care – behavioral health	100%
Hospital care – substance use disorder	
Consultations	
Neuropsychological testing	
Psychological testing	
Behavioral health	
Autism spectrum disorders – ABA	90% after deductible
Electro-Convulsive Therapy (ECT)	100%
Intensive Outpatient Program (IOP)	100%
Neuropsychological testing – outpatient	90%
Outpatient behavioral health	90%
Partial Hospitalization Program (PHP)	100%
Psychological testing – outpatient	90%
Substance use disorder	
Intensive Outpatient Program (IOP)	100%
Outpatient care – substance use disorder (Includes office based opioid treatment and methadone maintenance)	90%
Partial Hospitalization Program (PHP)	100%
Residential Substance Use Disorder treatment	100%

What is not covered

The following behavioral health services aren't covered under the State Health Plan:

- Art therapy
- Biofeedback
- Claims deem fraudulent which, through the exercise of due diligence by contractor could have been prevented
- Completion on any insurance form
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance use disorder
- Hypnotherapy
- Marital counseling
- Medical services or drugs not administered for BH/SU treatment
- Music therapy
- Phone consultations or therapeutic phone questions
- Psychodrama
- Recreation therapy
- Residential mental health
- rTMS
- Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide
- Services received at private residences (except for autism spectrum disorder to treat ABA)
- Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member
- Services provided while the member is not covered for this benefit
- Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice

State Health Plan PPO

Medical and Behavioral Health/ Substance Use Disorder Benefits

Grievances and Appeals

Your right to file an internal grievance

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to the Blue Cross Customer Service Center. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing an internal grievance procedure, including a managerial-level conference, if you believe we have violated Section 402 or 403 of Public Act 350. You will find the specific provisions of those two parts of the Act at the end of this section.

Internal grievances

Standard internal grievance procedure

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

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

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

  - You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.
- In addition to the information found above, you should also know:
  - You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the standard internal grievance procedure.
  - Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish. You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited internal grievance procedure

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

The procedure is as follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

  Call the expedited grievance hot line: 313-225-6800.

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

- In addition to the information found above, you should also know:
  - — You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the expedited internal grievance procedure.
  - — If our decision is communicated to you orally, we must provide you with written confirmation within two business days.

External review

Standard external review

If you complete our standard internal grievance procedure and disagree with our final determination, or if we fail to provide you with our final determination within 35 days from the date, we receive your written grievance, you may request an external review from the commissioner. You must do so within 60 days of the date you received either our final determination or the date our final determination was due. Mail your request for a standard external review, including the required forms that we will supply to you, to:

Department of Insurance and Financial Services
Appeals Section
Health Plans Division
P.O. Box 30220
Lansing, MI 48909-7720

If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the commissioner will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the commissioner within seven days after you submit your request for external review.

The assigned independent review organization will recommend within 14 days whether the commissioner should uphold or reverse our determination. The commissioner must decide within seven business days whether to accept the recommendation. The commissioner's decision is the final administrative remedy.

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

Expedited external review

Once you have filed a request for an expedited internal grievance, you may also request an expedited external review from the commissioner before you receive our determination. A physician must substantiate orally or in writing that you have a medical condition for which the time frame for completion of an expedited internal grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service. You must make your request within 10 days of your receipt of our adverse determination, and you may do so in writing or by telephone.

If in writing, mail your request to:

Department of Insurance and Financial Services
Appeals Section
Health Plans Division
P.O. Box 30220
Lansing, MI 48909-7720

If by telephone, call toll-free number: **1-877-999-6442**.

Immediately after receiving your request, the commissioner will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the commissioner should uphold or reverse our determination. The commissioner must decide within 24 hours whether to accept the recommendation. The commissioner's decision is your final administrative remedy.

Sections 402 and 403 of Public Act 350

What we may not do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate
- Refuse to pay claims without conducting a reasonable investigation based upon the available information
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage
- Make known to the member administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim
- Attempt to settle a claim on the basis of an application that was altered without notice to, knowledge or consent of the subscriber under whose certificate the claim is being made
- Delay the investigation or payment of a claim by requiring a member or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of verification

- Fail to provide promptly a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate

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

The things we cannot do under this section are:

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

What we must do

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim.

We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

Disclosure required by the Patient Protection Act

Upon enrollment, we must provide subscribers, in plain English, a written description of the terms and conditions of Blue Cross Blue Shield of Michigan's certificate. The form must list all information that is available to the member upon request.

The following information is available to you by calling or writing Blue Cross Blue Shield of Michigan customer service at the number or address listed on page one of this book. You can request:

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

We require that your request for information be submitted to Blue Cross Blue Shield of Michigan in writing.

Appeals to the Michigan Civil Service Commission

If you have exhausted the internal grievance procedures with Blue Cross, you may appeal a denial by Blue Cross to the Employee Benefits Division of the Michigan Civil Service Commission. The complaint must be received within 28 calendar days after the date that the final internal decision of Blue Cross was issued.

Appeals can be sent by mail or email.

Mail: Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909

Email: **MCSC-EBD@michigan.gov**

State Health Plan PPO

Medical and Behavioral Health/ Substance Use Disorder Benefits

Glossary of Terms

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days.

The facility is not primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance use disorder treatment

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Ambulatory Detoxification is non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of the client’s needs and motivation toward continuing participation in the treatment process.

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

Appeal is a complaint made if a member disagrees with a decision to deny a request for health care services or payment for services already received, or to stop services that are being received.

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved amount is the Blue Cross maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved Autism Evaluation Center (AAEC) is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

Approved facility is a hospital that provides medical and other services, such as skilled nursing care or physical therapy, and has been approved as a provider by Blue Cross. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by either the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a facility that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by Blue Cross or an affiliate of Blue Cross.

Autism Spectrum Disorders (ASD) are disorders that are defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the Blue Cross allowed amount is $70, the provider may bill you for the remaining $30. A Blue Cross PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

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

Blue Cross Blue Shield of Michigan (Blue Cross) is a nonprofit, independent company. Blue Cross is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

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

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

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Coinsurance is a member's out-of-pocket percentage of the Blue Cross allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

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

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

Covered services are services, treatments or supplies identified as payable under the SHP PPO. Covered services must be medically necessary to be payable, unless otherwise specified.

Crisis Stabilization Bed (CARES Unit) is an inpatient crisis intervention service that provides intensive short-term rapid assessment, stabilization, and disposition management for children under the age of 18 experiencing an acute behavioral health crisis who can be stabilized or discharged within 72 hours. The CARES Unit is designed to provide diversion from inpatient care for those children/adolescents who are in psychiatric crisis and who can be rapidly stabilized. Referrals will come primarily from local Emergency Mobile Psychiatric Services (EMPS) and affiliated Hospital Emergency Departments.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

Deductible is the specified amount you pay each calendar year for services before your plan begins to pay.

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

Designated facility is a facility that Blue Cross determines to be qualified to perform a specific organ and bone marrow transplant.

Detoxification is an immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs.

Diabetes - Self management See the document entitled, 'State Health Plan PPO - Preventive services for active employees' located at **bcbsm.com/som** for benefit details.

Durable medical equipment (DME) is 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. A physician must prescribe this equipment.

Electro Convulsive Therapy (ECT) is brain stimulation techniques such as electroconvulsive therapy (ECT) can be used to treat major depression that hasn't responded to standard treatments.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions
- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied
- Application of butterfly suture

- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

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

Excluded services are health care services for which your health plan does not pay or cover.

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

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

Extended Day Treatment (EDT) is a community-based program for children and their families that offers a structured, intensive, therapeutic milieu with group, family and individual therapy services. Services are typically after school for several days per week and the program can last up to six months. EDT provides a broad range of treatment services and psycho-social interventions.

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

Grievance is a complaint that does not involve coverage or payment disputes. For example, a complaint regarding one of our network providers or a complaint concerning the quality of care is considered a grievance. This type of complaint does not involve a request for an initial determination or an appeal.

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

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

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

Intensive Outpatient Services (IOP) is an integrated program of outpatient psychiatric services that are designed for more intensive treatment than routine outpatient psychiatric services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance use disorder, or an outpatient psychiatric clinic for children.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person expects that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity for payment of hospital services requires that all of the following conditions are met:

- The covered service is for the treatment, diagnosis of the 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 the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

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

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that the covered service is:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medication Assisted Treatment (MAT) is an approach to treating both opioid and alcohol substance use disorders. The FDA has approved several different medications to treat Opioid Use and Alcohol Use Disorders. These medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused substance. Research has shown that when provided at the proper dose, MAT medications used have no negative effects on a person's intelligence, mental capability, physical functioning, or employability.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in Blue Cross membership records.

Methadone Maintenance is treatment where the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder.

Network is a group of doctors, hospitals, DME and other health care providers contracted with Blue Cross to provide services to members. Members typically pay less for using a network provider.

Nonparticipating providers are providers that have not signed participation agreements with Blue Cross agreeing to accept the Blue Cross payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross-approved amount as payment in full on a per claim basis.

Observation consists of services up to 48 hours at a hospital to assess whether further inpatient services or community-based services might be needed; usually following a visit to the Emergency Room.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Out-of-network refers to services not rendered by a Blue Cross PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the Blue Cross PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved Blue Cross amount.

Outpatient Services (for behavioral health and substance use disorder) includes behavioral health evaluation and treatment services such as individual, group, family therapy, medication management, Autism Spectrum Disorder services, psychological and developmental testing, consultation, and case management that are provided to people who have a primary behavioral health diagnosis. Services may be provided in a freestanding clinic, hospital outpatient clinic, or by a group practice or solo practitioner who is a licensed behavioral health professional.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

Partial Hospitalization Program (PHP) is a program used to treat mental health and/or substance use disorders. In partial hospitalization, the member continues to live at home, but commutes to a hospital-based or clinic-based program several days per week.

Participating providers are providers who have signed agreements with Blue Cross to accept the Blue Cross-approved amount for covered services as payment in full.

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

Per claim is a provider's acceptance of the Blue Cross-approved amount as payment in full for a specific claim or procedure.

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

Physician or professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD), or a fully licensed psychologist.

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

Psychiatric Hospitalization consists of services where a member stays overnight at a hospital (inpatient) either at a general hospital, psychiatric hospital, or freestanding detox service in the case of a substance use disorder.

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-Blue Cross PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Residential Substance Use Disorder Treatment Program is a community based (non-hospital) facility that provides medical and other services specifically for substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in this type of a program is sometimes called intermediate care and may include subacute detoxification early in the treatment course.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

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

Specialty hospital is a hospital, such as a children's hospital or a chronic disease hospital that provides care for a specific disease or population.

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

Stem cells are primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the SHP PPO.

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر ئێوە، یان کەسێک کە ئێوە یارمەتی دەدەن، پێویستیان بە یارمەتی هەیە، مافی ئەوەتان هەیە بە زمانی خۆتان یارمەتی و زانیاری بەدەست بهێنن بەبێ هیچ تێچوونێک. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بکەن بە ژمارەی خزمەتگوزاری بەکارهێنەران کە لەسەر پشتەوەی کارتەکەتانە، یان بە ژمارە 877-469-2583 TTY:711 ئەگەر ئێوە پێشتر ئەندام نین.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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