Member Handbook
for employees of
Western Michigan Health Insurance Pool
Flexible Blue 2 HSA Plan

Preferred Provider Organization (PPO)
Including:
Prescription Drugs
Blue Cross Blue Shield
Customer Service Directory

We are committed to providing you with excellent customer service. When you have a question or need help, you can call a knowledgeable customer service representative or go to one of the websites listed below.

Where to Call or Write for Customer Service:
When writing or calling, please provide your Enrollee ID from your Blue Cross Blue Shield ID card. We offer translation services for non-English speaking members. Over 140 languages are available. You can obtain language assistance by calling the telephone inquiries phone number listed below.

Telephone Inquiries: 1-877-752-1233 (TTY users: start by dialing 711)

Note: You can get information about your coverage 24 hours a day through our interactive voice response system by calling the telephone inquiry phone number. See the “General Information” section of this handbook for more information about the IVR system.

Written Inquiries: Blue Cross Blue Shield of Michigan
West Michigan Customer Service
P.O. Box 230555
Grand Rapids, MI 49523-0555

If you suspect fraud, call our fraud hotline: 800-482-3787

Write to the Anti-fraud Unit: Anti-Fraud Unit — Mail Code 1825
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Anti-fraud unit website: bcbsm.com/health-care-fraud
**Prescription Drug Information:**

Prescription drug inquiries: 1-877-752-1233  
Express Scripts by mail inquiries: 800-903-8346  
Website: [bcbsm.com](http://bcbsm.com) (login or register online to access your account)  
Out-of-network claims: Express Scripts  
Walgreens Specialty Pharmacy, LLC (Specialty Drugs)  
866-515-1355

**Health Savings Account Inquiries**  
877-284-9840  
[bcbsm.com](http://bcbsm.com) (login or register online to access your account)

**Network Provider Locator:**  
800-810-BLUE (2583)  
[bcbsm.com](http://bcbsm.com) (you can access Network Providers online by clicking on "Find a Doctor")

**Website Address:**

Blue Cross Blue Shield of Michigan: [bcbsm.com](http://bcbsm.com) (login or register online to access your account)

**Member Self Service**

This feature allows you to check on a claim you sent to us, get up to date information on your deductibles and out of pocket expenses, view or print EOBs or order a BCBS ID card.

Visit my health care benefits [bcbsm.com](http://bcbsm.com) (login or register online to access your account)

**Blue Cross® Health & Wellness**

Your benefits include Blue Cross Health & Wellness, our personalized program designed to help you learn as much as you can about your health. When you have the health information you need, you can make better decisions.

Blue Cross Health & Wellness provides you with educational resources to help you understand and manage a disease and interactive Web resources where you can learn about your health and how to improve it.
Call Monday through Friday from 8 a.m. to 6 p.m.: 1-800-775-BLUE (2583)
Or visit the Blue Cross Health & Wellness website: bcbsm.com (login or register online to access your account)
Introduction

Blue Cross Blue Shield is pleased to provide you and your family with this handbook that explains your health care coverage. When you're well informed about your coverage and your health care benefits, you'll have the confidence and security that come from knowing that health care coverage is available when you need it.

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

When you come across a word you don’t understand, look in the Glossary at the back of the handbook. It contains the definitions of many health care terms that may be unfamiliar to you.

This book is a handy reference. However, if you have questions that are not answered in the handbook, please contact a Blue Cross Blue Shield customer service representative.

This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Blue Cross Blue Shield of Michigan administers the benefit plan for your employer and provides administrative claims payment services only. Blue Cross Blue Shield of Michigan does not insure your coverage nor do we assume any financial risk or obligation with respect to your claims. Benefits and future changes in benefits are the responsibility of your employer. Information concerning members may be reviewed by Blue Cross Blue Shield of Michigan, and may also be reviewed by your employer, on a limited basis, for specific purposes permitted by law.

This coverage is provided pursuant to a contract entered into in the state of Michigan and must be interpreted under the jurisdiction and according to the laws of the state of Michigan.
Table of Contents

Section 1: General Information

Your Identification Card is Important ............................................................... 1
Preventing Fraud ................................................................................................. 2
Customer Service .............................................................................................. 2
24/7 Customer Service ...................................................................................... 2
National Health Care Reform ............................................................................. 3

Section 2: Eligibility Guidelines

Health Care Coverage Eligibility Chart ............................................................ 8
Dependents ........................................................................................................... 9
Dependent Coverage .......................................................................................... 9
Disabled Dependents ......................................................................................... 9
Domestic Partners .............................................................................................. 9
Same Gender Spouse ......................................................................................... 10
Special Enrollment Periods ................................................................................ 10
Making Membership Changes — Your Responsibility ........................................ 11
When Coverage Ends ......................................................................................... 11
Continuing Health Care Coverage on Your Own ............................................... 11
COBRA Continuation Coverage ....................................................................... 11
Children’s Health Insurance Program Reauthorization Act (CHIPRA) ............... 12

Section 3: Selecting a Health Care Provider

Network Providers ............................................................................................. 14
Out-of-Network but Participating Providers ...................................................... 14
Non-Participating Providers .............................................................................. 15
Change of Network Status ................................................................................. 15
Emergency Services by Out-of-Network Providers ........................................... 15
Referral to Out-of-Network Providers ............................................................... 15
Coverage When You Travel ............................................................................. 16
  Travel across the United States ...................................................................... 16
  Travel Outside of the United States ............................................................... 16
BlueCard® Program ............................................................................................ 16
  Out-of-Area Services ....................................................................................... 16
  A. BlueCard® Program ................................................................................... 17
  B. Negotiated (non-BlueCard Program) National Account Arrangements ....... 17
  C. Non-Participating Healthcare Providers Outside BCBSM’s Service Area .... 18

Section 4: Making the Most of Your Health Care Plan

Medical Coverage ............................................................................................. 19
Prescription Drugs Coverage ............................................................................ 19
Payment of Benefits ......................................................................................... 19
Value Added Resources ..................................................................................... 19
  My Online Health Care Benefits ................................................................. 19
  Blue Cross® Health & Wellness ...................................................................... 20
# Section 5: Health Savings Account

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Here’s how it Works</td>
<td>23</td>
</tr>
<tr>
<td>Universal HSA Principles for Consumers</td>
<td>23</td>
</tr>
<tr>
<td>HSA Eligibility Rules</td>
<td>24</td>
</tr>
<tr>
<td>HSA Contribution Rules</td>
<td>27</td>
</tr>
<tr>
<td>HSA Spending Rules</td>
<td>29</td>
</tr>
<tr>
<td>Why HSAs Were Designed this Way</td>
<td>30</td>
</tr>
<tr>
<td>Allowable HSA Investments</td>
<td>32</td>
</tr>
<tr>
<td>Allowable Expenditures from Your HSA</td>
<td>33</td>
</tr>
<tr>
<td>Non-Allowable Expenditures from Your HSA</td>
<td>35</td>
</tr>
</tbody>
</table>

# Section 6: Your Health Care Benefits

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Necessity</td>
<td>36</td>
</tr>
<tr>
<td>Your Out-of-Pocket Costs</td>
<td>36</td>
</tr>
<tr>
<td>Benefit Period</td>
<td>36</td>
</tr>
<tr>
<td>Deductible</td>
<td>36</td>
</tr>
<tr>
<td>Copayment</td>
<td>36</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>37</td>
</tr>
<tr>
<td>Hospital Benefits — Inpatient Care</td>
<td>41</td>
</tr>
<tr>
<td>Precertification of Hospital Admissions</td>
<td>41</td>
</tr>
<tr>
<td>Room and Board</td>
<td>41</td>
</tr>
<tr>
<td>General Medical Care</td>
<td>41</td>
</tr>
<tr>
<td>Behavioral Health Care and Substance Abuse Treatment</td>
<td>41</td>
</tr>
<tr>
<td>Hospital Services and Supplies</td>
<td>42</td>
</tr>
<tr>
<td>Hospital Benefits — Outpatient Care</td>
<td>43</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>43</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>44</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>44</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>45</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>47</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care</td>
<td>48</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Treatment</td>
<td>48</td>
</tr>
<tr>
<td>Additional Hospital Services and Programs</td>
<td>48</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>48</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>48</td>
</tr>
<tr>
<td>Home Hemophilia Program</td>
<td>49</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>49</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>49</td>
</tr>
<tr>
<td>Human Organ Transplants</td>
<td>49</td>
</tr>
<tr>
<td>Organ and Tissue Transplants</td>
<td>49</td>
</tr>
<tr>
<td>Bone Marrow Transplants</td>
<td>50</td>
</tr>
<tr>
<td>Oncology Clinical Trials</td>
<td>53</td>
</tr>
<tr>
<td>Specified Human Organ Transplants</td>
<td>56</td>
</tr>
<tr>
<td>Physician Benefits</td>
<td>59</td>
</tr>
<tr>
<td>Office Visits</td>
<td>59</td>
</tr>
</tbody>
</table>
Section 1:  
General Information

Your Identification Card is Important  
As an enrolled member of a Blue Cross Blue Shield ("BCBS") plan, you receive BCBS identification cards. Your ID cards allow you to obtain services covered under your health care plan. Only the subscriber’s name appears on the ID cards; however, the cards are for use by all of the subscriber’s eligible dependents.

The numbers on your ID card, especially the Enrollee ID, are very important in identifying your type of coverage. The Enrollee ID is the alpha numeric number found on your ID card.

Here are some tips about your ID card:

- Make sure you carry the latest card. Using outdated cards may delay payment of claims.
- You may request additional cards, without cost, for your eligible dependents and replace lost or stolen cards by calling your BCBS customer service representative at the toll-free phone number listed on the inside front cover of this handbook. **You can also visit bcbsm.com** (login or register online to access your account) to order ID cards.
- If your card is lost or stolen, you can still receive services, but you should report the loss of your card immediately to your employer or to your BCBS customer service representative.
Preventing Fraud
We work diligently to prevent fraudulent use of your ID card. Only you and your eligible dependents may use the cards issued for your health care plan. Lending your card to anyone not eligible to use it is illegal. Your health care provider may ask for identification other than your ID card. Checking identification helps prevent unauthorized use of your card. If you suspect health care fraud against BCBS, contact our Anti-Fraud Unit at the phone number or address listed on the inside front cover of this handbook. All inquiries are strictly confidential.

Customer Service
If you have questions about your health care plan, please contact your BCBS customer service representative. For your convenience, we have listed our customer service phone numbers and addresses on the inside front cover of this handbook.

To help the customer service representative serve you better, here are some tips to remember:
• Have your Enrollee ID ready. It is the alpha numeric number found on your BCBS ID card.
• In addition to your Enrollee ID, please provide a daytime telephone number.
• If you are questioning a service, please provide:
  - Patient’s name
  - Date the patient was treated
  - Name of doctor or hospital
  - Type of service
  - Charge for each service
• When sending us bills, forms or other papers, please make copies of them. Send the originals to BCBSM and keep the copies for your records. Make sure your Enrollee ID is on each page.

24/7 Customer Service
When you have a question about your benefits, claims, coordination of benefits, health care providers or you need an ID card, you can get the help you need by using our interactive voice response automated servicing system. The system is available 24 hours a day, every day. You are immediately connected to the system when you dial your customer service telephone number.
National Health Care Reform
The Patient Protection and Affordable Care Act (PPACA) required several benefit changes be made beginning with plan years starting on or after September 23, 2010.

The following health care reform benefits were implemented on the group’s plan year date after September 23, 2010. Most groups implemented Health Care Reform (HCR) benefits on January 1, 2011.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extending dependent coverage up to age 26</td>
<td>Adult children can join or remain on their parents’ plan whether or not they are:</td>
</tr>
<tr>
<td></td>
<td>• married;</td>
</tr>
<tr>
<td></td>
<td>• living with the parent;</td>
</tr>
<tr>
<td></td>
<td>• in school;</td>
</tr>
<tr>
<td></td>
<td>• financially dependent on the parent;</td>
</tr>
<tr>
<td></td>
<td>• eligible to enroll in their employer’s plan, with one temporary exception: Until 2014, “grandfathered” group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parents’ plan.</td>
</tr>
<tr>
<td>Removing pre-existing condition exclusions for</td>
<td>Health plans that cover children may no longer refuse coverage – or limit benefits – to anyone under age 19 for pre-existing health conditions.</td>
</tr>
<tr>
<td>children up to age 19</td>
<td></td>
</tr>
<tr>
<td>Removing lifetime dollar limits</td>
<td>PPACA requires that health plans remove “lifetime” dollar limits on essential services.</td>
</tr>
<tr>
<td>Removing annual dollar limits</td>
<td>PPACA requires that annual dollar limits on essential benefits be restricted and eventually removed beginning with plan years starting on or after September 23, 2010.</td>
</tr>
<tr>
<td>Clarifying emergency services</td>
<td>The law makes in-network and out-of-network emergency services cost the same to the member. Health plans may not impose prior approval for emergency services.</td>
</tr>
<tr>
<td></td>
<td>These provisions were already standard for BCBSM group health plans.</td>
</tr>
<tr>
<td>Provision</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Providing preventive services and immunization benefits with no cost share* | Members do not have to pay a copayment, co-insurance or deductible to receive preventive health services, such as recommended screenings, vaccinations and counseling. For example:  
- Blood pressure, diabetes, and cholesterol tests  
- Many cancer screenings, including mammograms and colonoscopies  
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use  
- Routine vaccinations against diseases such as measles, polio or meningitis  
- Travel immunizations (such as Rabies, Typhoid, Yellow Fever, and Japanese Encephalitis)  
- Flu and pneumonia shots  
- Counseling, screening, and vaccines to ensure healthy pregnancies  
- Regular well-baby and well-child visits, from birth to age 21 |
| *This provision may not apply to “grandfathered” group health plans. |
| Prohibiting rescissions with limited exceptions | The law prevents retroactive cancellation of coverage, or rescissions, except in the case of:  
- Intentional fraud  
- Misrepresentation  
- Nonpayment of premiums  
If a rescission of benefits does happen, the member is entitled to a 30-day written notice prior to the termination. |
| Doctor/Patient Access | The law enables members to choose a participating OB/GYN as their primary care physician (PCP), and a Pediatrician as their child’s PCP if desired.  
In addition, members can have an appointment with an OB/GYN without a referral. However, the plan retains the right to impose prior |
In compliance with PPACA, BCBSM began covering additional or expanded women’s preventive services without cost sharing when services are rendered by in-network providers.

The following health care reform benefits were implemented on the group’s plan year date beginning on or after August 1, 2012. Most groups implemented these benefits on January 1, 2013.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Preventive Benefits</td>
<td>• Well Woman Visits</td>
</tr>
<tr>
<td></td>
<td>• Screening for gestational diabetes</td>
</tr>
<tr>
<td></td>
<td>• Human papillomavirus, or HPV, testing and HPV plus Pap Smear testing</td>
</tr>
<tr>
<td></td>
<td>• Counseling for sexually transmitted diseases</td>
</tr>
<tr>
<td></td>
<td>• Counseling and screening for Human immune-deficiency virus (HIV)</td>
</tr>
<tr>
<td></td>
<td>• Screening and counseling for interpersonal and domestic violence</td>
</tr>
<tr>
<td></td>
<td>• Contraceptive counseling and methods (including anesthesia for contraceptive surgeries)</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding supplies</td>
</tr>
</tbody>
</table>

In compliance with PPACA, BCBSM was required to make several benefit changes beginning with plan years starting on or after January 1, 2014.

The following health care reform benefits were implemented on the group’s plan year date on or after January 1, 2014.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removing pre-existing condition exclusions to anyone age 19 or older.</td>
<td>Health plans may no longer refuse coverage - or limit benefits - to anyone age 19 or older for pre-existing health conditions.</td>
</tr>
<tr>
<td>Waiting Periods</td>
<td>A group health plan cannot apply any waiting period that exceeds 90 days for employees eligible to participate in the group health plan.</td>
</tr>
<tr>
<td>In Network Cost Share Accumulation</td>
<td>Out-of-Pocket maximum includes deductible, coinsurance and copayments</td>
</tr>
<tr>
<td>Deductible Limits and Out-Of-Pocket Maximums</td>
<td>Ensure that annual out-of-pocket cost-sharing and deductible limits do not exceed applicable</td>
</tr>
<tr>
<td>Provision</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tobacco cessation counseling</td>
<td>Health plans must cover, without cost sharing, screening for tobacco use and for those who use tobacco, at least two tobacco cessation attempts per year. This includes coverage for 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization. Plans prescription drug program will cover all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.</td>
</tr>
<tr>
<td>Lung cancer screening</td>
<td>Health plans must cover annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.</td>
</tr>
<tr>
<td>Fluoride Varnish</td>
<td>Health plans must cover, without cost sharing, the application of fluoride varnish, twice a year, when performed by a MD/DO or CNP, for members through age five. (effective 5/1/2015)</td>
</tr>
</tbody>
</table>

This information is based on BCBSM’s review of the national health care reform law and is not intended to impart legal advice. This overview is intended as an educational tool only and does
not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.
Section 2: Eligibility Guidelines

When you are eligible to enroll for health care coverage, your employer will provide you with an application and assist you with the enrollment process. You may enroll your spouse and eligible dependents. To ensure that these records are kept up to date, you must promptly report any changes (birth of a newborn, change of address, marriage, etc.) to your employer. Guidelines for reporting changes are outlined later in this section.

Health Care Coverage Eligibility Chart

<table>
<thead>
<tr>
<th>Eligible Employee or Dependent</th>
<th>Qualification for coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active employee</td>
<td>Date of hire</td>
</tr>
<tr>
<td>Spouse</td>
<td>Date of marriage</td>
</tr>
<tr>
<td>Newborn</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Dependent children</td>
<td>Coverage continues until the End of the Month in which the dependent turns 26</td>
</tr>
<tr>
<td>Disabled dependents</td>
<td>Must be totally and permanently disabled and <strong>you must notify BCBS no later than 31 days after the end of the calendar year the child turns 19.</strong></td>
</tr>
</tbody>
</table>

Please contact your benefits department for further information.

**Note:** If you are still actively employed when you are age 65 or older, special options are available to you. Please refer to the “Medicare and Supplemental Coverage” section in this handbook.
Dependents
Eligible dependents include your spouse and your children. Eligible children include:

- **Biological children**
- **Adopted children** may be enrolled as of the date of final adoption or the date of a petition for adoption if the child resides with the subscriber and the subscriber notifies BCBSM. In either case, BCBSM must be notified within 31 days of the date of final adoption or the date of the petition for adoption. A copy of the petition for adoption must be submitted.
- **Dependent stepchildren** are eligible when a subscriber marries a spouse who has dependent children. The subscriber must add the spouse and stepchildren within 31 days of the marriage. The coverage effective date for the spouse and stepchildren will be the date of marriage. If the spouse and dependent stepchildren are not added within 31 days of marriage, they can be added at your group’s annual open enrollment period.
- **Children under legal guardianship** are eligible to enroll under a subscriber’s contract on the date legal guardianship is granted to the subscriber or prior to that date if the subscriber has filed a petition for legal guardianship and the child has established residency with the subscriber. When notification is made within 31 days of the date of either of these events, coverage for the children will become effective as of the date of the event. One of two of the following documents is required:
  - A sworn statement that includes the date of petition for legal guardianship and the date the child established residency
  - A statement from the court verifying legal guardianship has been granted
- **Children eligible because a court order** puts responsibility for the dependents’ health care on the subscriber or the spouse. The dependents are eligible for coverage immediately.

Dependent Coverage
Dependents are those related to the employee by birth, marriage, legal adoption or legal guardianship. Dependent children's eligibility is through the End of the Month in which the dependent turns 26.

Disabled Dependents
Disabled dependents are eligible for coverage under your contract at any age, if they are totally and permanently disabled by age 26, and you notify BCBSM in writing of the condition no later than 31 days after the end of the calendar year the child turns 19. The disability must be due to developmental disability or physical disability that prevents a dependent from being self-supporting.

Disabled dependents must be unmarried and dependent on you for support and maintenance to be covered. You will be required to provide verification of a dependent's total and permanent disability.

Domestic Partners
A subscriber’s domestic partner is eligible as a dependent if all of the following requirements are met:
• The subscriber and domestic partner are the same or opposite gender.
• Both partners are 18 years of age or older.
• Neither the subscriber nor the domestic partner is legally married to anyone else.
• The subscriber and domestic partner are not related by blood in a way that would prevent them from being legally married.
• The subscriber provides proof that he or she has shared a residence with the domestic partner for at least 12 consecutive months. (Proof of shared residency may be established by a driver’s license, voter registration, student identification card, city or county registration or other documented proof.)
• A signed and notarized Affidavit of Domestic Partnership is submitted to your benefits department.
• These documents are forwarded to BCBSM for final approval.

Coverage for the domestic partner will become effective 90 days from the approved application date.

If you have questions or need any of the above mentioned forms, please contact your benefits department.

**Same Gender Spouse**
A subscriber's same-gender spouse is eligible for coverage as a spouse if the couple is legally married and meets the group's eligibility requirements.

**Special Enrollment Periods**
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future enroll yourself and your dependents in this plan, if:

• The other coverage is terminated as a result of loss of eligibility or termination of employer contributions for the other coverage, provided that you request enrollment within 31 days after your other coverage or the employer contribution toward that coverage ends. “Loss of eligibility” includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim.
• You have a new dependent as a result of marriage, birth, adoption, placement for adoption or legal guardianship, provided that you request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

If you declined enrollment because you had COBRA continuation coverage under another plan, you must exhaust your COBRA coverage before you may enroll in this plan under a special enrollment period. Otherwise, you must wait until the next annual open enrollment period.
Making Membership Changes — Your Responsibility

It is important that your membership records be kept up-to-date so BCBS can process your claims quickly and correctly. Please report any changes to your employer promptly. Any changes involving adding or removing a dependent due to marriage, birth, divorce, dependent no longer eligible for coverage, etc. or changing an address must be made within 31 days of the change.

When Coverage Ends

The chart below gives the reason and the end date of coverage when removing dependents.

<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Reason for Losing Coverage</th>
<th>Effective End Date of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Divorce or legal separation</td>
<td>Date of divorce or legal separation</td>
</tr>
<tr>
<td>Dependent children</td>
<td>Passed age of eligibility</td>
<td></td>
</tr>
</tbody>
</table>

Continuing Health Care Coverage on Your Own

When you are no longer eligible for health care coverage through your employer, coverage for you and your dependents ends. However, you may continue temporary coverage through your employer. This is called COBRA continuation coverage. A federal law requires employers of 20 or more people to offer a temporary extension of coverage to those who lose group coverage. This extension applies to the employee, spouse and dependent children including children born or adopted after you become eligible for COBRA who are enrolled within 60 days of the qualifying event. The person who lost the group coverage is called a "qualified beneficiary." To maintain coverage for the entire eligibility period, you (or your dependents) must pay the cost of coverage.

COBRA Continuation Coverage

Your employer will notify you and your dependents when you are eligible for this temporary extension of your health care coverage. In the case of your death, your employer must notify your dependents about their eligibility. In case of divorce, you or your former spouse must notify the employer within 60 days in order to be eligible for this coverage. COBRA coverage must be elected within 60 days you lose coverage or 60 days after your employer sends you notice. In every case, you (or your dependents) must notify your employer of your decision to continue coverage through your employer. The length of time this continuation coverage is available to you and your dependents depends on the reason you become eligible for this coverage. You or your dependents will be required to pay the entire applicable cost of coverage, plus an administrative fee.

Employee Continuation Coverage

If you lose your coverage because of layoff, reduction in your hours of employment or termination of your employment (for other than gross misconduct), coverage is available to you and your dependents for up to 18 months.

Continuation coverage is extended to 29 months if:

- You or any qualified beneficiaries are determined to be disabled by the Social Security Administration at the time coverage is terminated.
• You or any qualified beneficiaries are determined to be disabled by the Social Security Administration any time during the first 60 days of COBRA coverage.

**Dependent Continuation Coverage**
Your dependents have the right to continue their coverage for up to 36 months when they are no longer eligible under your plan because:

• Your dependents’ coverage under the plan ends due to your death.
• You become entitled to Medicare, and your spouse or dependents lose group coverage as a result.
• Divorce or legal separation causes a spouse to lose coverage.
• Children no longer meet dependent eligibility requirements under your plan.

**Level of Continuation Coverage**
If you or your dependents choose COBRA continuation coverage through your employer, you will be offered the same level of benefits as active employees.

You may continue the COBRA coverage you select until the earliest of the following situations:

• The end of your continuation period.
• The date your employer no longer provides coverage to any of its employees.
• The date you do not make payment for COBRA coverage.
• The date you or your dependents become covered under another group health care plan (unless that plan includes exclusions or limitations about pre-existing conditions that apply to you).
• The date you or your dependents become entitled to Medicare.

**Children’s Health Insurance Program Reauthorization Act (CHIPRA)**
The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires all health plans to allow a special enrollment period should you or your dependents lose eligibility under Medicaid or Children’s Health Insurance Program (CHIP) coverage through states participating in a premium share subsidy to eligible participants.

You and your eligible dependents have 60 days to enroll in your group’s health plan under the following two circumstances:

• If you or your eligible dependents’ Medicaid or CHIP coverage is terminated due to loss of eligibility.
• If you or your dependents become eligible for a premium assistance program in the state in which you reside.

If you are enrolled in such a program, your health plan will not accept direct payment from the state.
Your group health plan is primary to any coverage under CHIP.
Section 3: Selecting a Health Care Provider

Your benefits are provided through the Preferred Provider Organization (PPO) health care plan. This plan is designed to provide you with the highest level of benefit payment and limit your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the PPO health care provider network.

There are three levels of participation in the BCBS provider network. The level of a health care provider’s participation impacts the costs for which you will be responsible. The three levels are:

- Network providers
- Out-of-network, but participating providers
- Non-Participating providers

Network Providers
To receive the highest benefit payment level, you should use health care providers who are in the PPO network. Network providers have signed agreements with BCBS, which means they agree to accept our approved payment, for a covered benefit, as payment in full. You will only pay for the in-network deductibles, coinsurances and copayments required by your coverage.

Ask your physician if he or she is in the BCBS PPO network in your plan area. If you need help locating a network provider, please call the phone number to locate a BCBS network provider or visit the website listed on the inside front cover of this handbook.

When you go to a network provider, you do not have to send a claim to us. Network providers submit claims to BCBS for you, and they are paid directly by BCBS.

Out-of-Network but Participating Providers
Although many providers are part of the BCBS PPO network, you have the freedom to visit an out-of-network provider and still receive coverage for covered services. Providers who are not part of the PPO network are called out-of-network providers.

When using an out-of-network provider, try to use a BCBS participating provider. Out-of-network but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not part of the PPO network, you must pay any required copayments and a higher deductible and coinsurance for your care.

When you go to out-of-network but participating providers, you usually don't have to submit claims. These providers, like network providers, submit claims to BCBS for you and the providers are paid directly by BCBS.
Non-Participating Providers

Non-Participating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services.

If your present providers do not participate with BCBS, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, coinsurances and copayments required by your plan along with charges for non-covered services.

You are usually required to pay non-participating providers directly and then you will submit the claim to BCBS for reimbursement. Remember, the amount BCBS reimburses you may be less than the amount your provider charged. You are responsible for the amount the provider charged above the BCBS approved amount.

Change of Network Status

Your physician is your partner in managing your health care. However, physicians retire, move, or otherwise cease to be affiliated with the BCBS PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network.

If you wish, you may continue your medical care with a physician who is no longer with the PPO network; however, you may be responsible for the difference between the BCBS approved amount and the provider’s charges, in addition to any deductibles, coinsurances and copayments required by your plan.

You can find physicians and hospitals in your area by calling the network provider locator or by visiting the website listed on the inside front cover of this handbook. You do not have to notify BCBS when you select or change providers. To make your appointment, just call the physician's office directly.

Emergency Services by Out-of-Network Providers

When an emergency situation occurs, you need to seek care from the nearest provider who may not always be a network provider. If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, your services will be paid at the in-network benefit level. The treatment must be for a true emergency as determined by BCBS. See the “Your Health Care Benefits” section of this handbook to find out what qualifies as a medical emergency.

Referral to Out-of-Network Providers

There may be times when your network physician will refer you to another physician, such as a specialist. Usually, your physician will refer you to a physician that is in the PPO network. If you are referred to an out-of-network physician, please contact your BCBS customer service representative to verify the referral process before receiving services. Covered medical services received from a referred physician may be subject to extra out-of-pocket costs.
Coverage When You Travel
When you travel across the country or around the world, your health care benefits go with you. The BlueCard® program gives you access to doctors, hospitals and other providers everywhere you travel.

Travel across the United States
Our extensive provider network makes it easy to find participating doctors, hospitals and other providers when you travel away from home. Out-of-state participating providers will bill their local Blue plan for any covered services you receive. This means faster payment to the provider and less out-of-pocket costs for you. Here’s how it works:

- **Participating providers** - Present your BCBS ID card to out-of-state participating providers. They will bill their local BCBS Plan for payment. Your provider also will accept the approved amount or negotiated rate (see “Glossary of Health Care Terms”) as payment in full. You are responsible for any member out-of-pocket costs (deductibles, coinsurances and copayments) as identified in this handbook. Remember, your out-of-pocket costs are usually calculated on the lower of the provider’s actual charge or the BCBS approved amount or negotiated rate.

  **Note:** If a participating provider bills you for charges other than what is required by your plan, remind the provider that he or she should accept the BCBS payment as payment in full.

- **Non-Participating provider** — If your out-of-state provider does not participate with the local BCBS Plan, ask if the provider can send the bill directly to us. If not, you will need to get an itemized receipt and send it to us for reimbursement. See the “Filing Claims” section of this handbook for instructions on how to submit a claim.

Travel Outside of the United States
When you travel outside of the United States, you still have access to your benefits as long as services are provided by a licensed physician or an accredited hospital.

Most hospitals and doctors in foreign countries will ask you to pay the bill upfront. Try to get itemized receipts, preferably written in English.

When you submit your claim, please indicate if the charges are in U.S. or foreign currency. Be sure to also indicate whether payment should go to you or to the provider. BCBS will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, less any deductibles, coinsurances and copayments that may apply.

BlueCard® Program
Out-of-Area Services
BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside the geographic area BCBSM serves, the claims for these services may be processed through one of
these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

Typically, when accessing care outside the geographic area BCBSM serves, you will obtain care from healthcare providers that have a contract (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield plan in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. BCBSM payment practices in both instances are described below.

**A. BlueCard® Program**

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by another Host Blue, BCBSM will remain responsible for fulfilling BCBSM’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside BCBSM’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

**B. Negotiated (non-BlueCard Program) National Account Arrangements**

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue. The amount
you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price.

C. Non-Participating Healthcare Providers Outside BCBSM’s Service Area
   1. Enrollee Liability Calculation
      When covered healthcare services are provided outside of BCBSM’s service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

   2. Exceptions
      In certain situations, BCBSM may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BCBSM will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.
Section 4:
Making the Most of Your Health Care Plan

This section provides general information about your total health care package. Your coverage includes the following benefits:

Medical Coverage
Your hospital and medical-surgical benefits are provided through the Preferred Provider Organization (PPO) health care plan. PPO is a cost-sharing plan that provides a wide range of benefits from inpatient hospital care to physician services. Using PPO network providers will limit your out-of-pocket costs. Please see the “Your Medical Coverage” section of this handbook for more information.

Prescription Drugs Coverage
You are responsible for a copayment and coinsurance for each covered prescription drug or refill. Your coverage pays the rest of the cost when you go to a participating/network pharmacy and follow coverage guidelines described in the “Prescription Drug Coverage” section of this handbook.

Payment of Benefits
Your coverage consists of services and supplies for which BCBS agrees to pay under the terms of your employer's coverage documents. Payable services and supplies are called “benefits” and are listed in your employer's coverage documents.

The payment amount for these benefits is called the “approved amount.” This is the BCBS maximum payment level allowed for the covered services. Deductibles, coinsurances and copayments and sanctions are deducted from the approved amount. All references to the approved amount in this handbook refer to the approved amount as determined by BCBS.

Value Added Resources
In addition to quality health care coverage, your plan includes the following resources:

My Online Health Care Benefits
The website, at bcbsm.com (login or register online to access your account), offers completely secure, password-protected access to the personal health benefit information you need most. You can create your own account and obtain real-time access to the following information:

- **Claims** — View your claim status, including current and previous claims for the past two years. You can also view claim payment information, claim summary and claim details.
- **Eligibility** — View the coverage for which you are eligible.
- **Deductibles and Maximums** — View your out-of-pocket costs and benefit limitations.
- **Provider Lookup** — View and find participating doctors and hospitals in the BCBS network, no matter where you live or travel. Visit bcbsm.com and click “Find a Doctor”.

To help you find the health care provider you need, you can:

- Enter searchable criteria — including gender, extended office hours, secondary languages spoken, hospital affiliation, board certification, medical specialty, patient centered medical home or Blue Distinction Center® designation.
- Compare providers easily — Compare up to six doctors or facilities side-by-side using selected criteria
- Read a review of a doctor
- Print the list
- Find out-of-state doctors
- Get cost-estimates – Research and compare for certain procedures
- Find services that require pre-approval – Some services are eligible for coverage only when your provider gets approval before giving them. You'll find a list at bcbsm.com/importantinfo. Click Approving covered services

You can find a network provider for the following services on our site:

- Primary care services, such as routine exams or general health issues
- Specialty care, for instance, if you need care for a heart condition or need a surgeon
- Behavioral care and substance abuse services
- Evening or weekend
- Services from a doctor who speaks another language
- Services located near you
- **ID Cards** — Request a replacement ID card to be sent to your home.
- **Downloads** — View, print or download forms and documents related to your health care coverage.
- **Coordination of Benefits** — Update additional health care coverage for each member on your contract.
- **Online Explanation of Benefits** — View what services have been paid by BCBS and what, if anything, you owe.

**Blue Cross® Health & Wellness**

Your employer believes your health and well-being is important, not only while you are at work but also while you are at home spending time with friends and family. That’s one of the main reasons your health care plan includes Blue Cross Health & Wellness, which is designed to help you get healthy, stay healthy or improve your quality of life if you are living with an illness. This resource offers a 24-hour nurse support hotline that you can call with questions about your health. It offers an effective disease management program to help you better manage your condition. In addition, if you have a specific condition, a nurse health coach may contact you by phone or send information to you.
The Blue Cross Health & Wellness website, powered by WebMD®, offers you a variety of helpful tools and resources that can help you learn about your health risks and ways to stay healthy or improve your health. The Blue Cross Health & Wellness site includes:

- An easy-to-use online health assessment that provides you with an analysis of your personal health risks and what you can do to improve your health
- Digital Health Assistant programs for exercise, nutrition, weight loss, tobacco cessation, stress relief and mental health that help you set goals and make small positive changes
- Health trackers so you can chart your healthy measures over time
- A Device and App Connection Center where you can sync your favorite fitness and medical devices and apps
- Message Board Exchanges that are professionally monitored
- Interactive programs such as calculators, guides, quizzes, slide show and more
- Videos, recipes, articles, health encyclopedias and more

To access the Blue Cross Health & Wellness website:
- Log in or register for [bcbsm.com](http://bcbsm.com).
- Click on the Health & Wellness tab to enter the Blue Cross Health & Wellness website. You’ll need to register for the website on your first visit.

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

**Member Savings Programs**
With our Healthy Blue XtrasSM savings program, you can access special member discounts on a variety of healthy products and services from companies across Michigan and businesses from around the U.S. through Blue365®, our national savings program. Save on things like gym memberships, yoga classes, groceries, travel, weight-loss programs and more.

Find out more about the Healthy Blue Xtras program and see all the great savings at [bcbsm.com/xtras](http://bcbsm.com/xtras). From there you can click on a link to take you the Blue365 website to view the national savings.

Here’s just a sample of some of our Health Blue Xtras and Blue365 partners*:

- LA Fitness
- Fitness 19
- QualSight® Lasik
- Weight Watchers®
- Dunham’s Sports®
- Moosejaw
• Reebok®
• Yoga Shelter
• Walking Spree
• Healthways Fitness Your Way

• Polar®
• American Home Fitness
• Better Health

To view all of your discounts online and learn how to redeem visit bcbsm.com/xtras. Then just show your BCBSM member ID card when you arrive at the business to save. *Partners and offers subject to change.
Section 5: Health Savings Account

A Health Savings Account (HSA) is like a 401(k) for health care. It is a tax-advantaged personal savings or investment account that individuals can use to save and pay for qualified healthcare expenses, now or in the future. Paired with a qualified high deductible health plan (HDHP), an HSA is a powerful financial tool that empowers consumers to be more actively involved in their healthcare decisions.

However, unlike other financial savings vehicles (Roth IRA, Traditional IRA, 401K, etc.), an HSA has the unique potential to offer triple tax savings through:

- Pre-tax or tax-deductible contributions to the HSA
- Tax-free interest or investment earnings
- Tax-free distributions, when used for qualified medical expenses

Contributions can be made by the employer, the employee/individual, or both. Tax-free withdrawals can be made to pay for qualified healthcare expenses incurred by the accountholder, spouse, children and other dependents.

HSAs are also portable, which means that individuals keep their HSAs, if changing jobs or becoming unemployed. Also, since the account is owned by the individual, there is no “use-it-or-lose-it” provision, like with a Flexible Spending Account (FSA). Instead, unused contributions roll over each year, with interest and/or investment earnings compounding on a tax-free basis, like an IRA or 401(k). HSAs offer the potential for long term, tax-free savings that can be used for future healthcare expenses, such as Medicare premiums and certain long-term care expenses and insurance.

Any adult who is not already enrolled in Medicare and is covered by an HDHP (and has no other first dollar coverage except for preventive care) may establish an HSA. There are no income limitations.

Here’s how it Works

Universal HSA Principles for Consumers

1. You must be enrolled in an HSA-qualified high deductible health plan (HDHP) to open or contribute to a Health Savings Account (HSA) in your own name.

2. Switching to an HDHP from a traditional low deductible health plan will substantially lower your health plan premium. The money you save in premiums can be deposited into your HSA.
3. The money in your HSA is entirely your own. Even if your employer makes contributions to your HSA, your employer cannot restrict what you can spend it on. Since it is your money, it also stays with you when you change jobs.

4. You are in charge of your HSA funds, making you and your doctor the decision makers, not some third party. Spending your own money also means that you will likely inquire more about the cost of your healthcare expenditures, helping to introduce marketplace competition into the world of healthcare.

5. There is no time limit as to when you can reimburse yourself for your healthcare expenses; you just need to keep legible receipts and records in case you do reimburse yourself or if you are audited.

6. You decide whether and how much to spend from the account for your medical expenses, whether to spend out-of-pocket or to save the HSA money for the future. Just like a 401(k), earnings that compound tax-free for several years have the potential to grow exponentially into a supplemental retirement nest egg. After age 65 (or if you’re disabled), funds can be withdrawn for non-qualified expenses without being subject to the 20 percent penalty, but ordinary income taxes still apply.

7. Anyone can contribute to another person’s HSA. The tax benefit from such a contribution is gained by the person receiving the contribution, not the person giving the contribution.

8. You decide which company will hold your HSA money (your trustee or custodian), and what type of investments you make with your account. Any investment allowed for IRAs is allowed for HSAs (please see Table A).

9. IRS Publication 502 provides a list of most allowable HSA expenditures and publication 969 adds further discussion and details of the HSA product.

   Please see Table D and E of this document for a partial and summary list of allowable (tax-free) and non allowable (not tax-free) expenditures from your HSA.

**HSA Eligibility Rules**

1. The account holder must be enrolled in an HSA-qualified high deductible health plan (HDHP).

2. An HSA-qualified HDHP has the following characteristics:

   a. |
   ---|---|---|
   **Minimum Deductible** | **2015** | **2016** |
   Self-only coverage | $1,300 | $1,300 |
   Family coverage | $2,600 | $2,600 |

Final - Western Michigan Health Insurance Pool/Flexible Blue 2, RX6/Health Care Handbook - revised 04/06/16
Page 24
The minimum deductible is indexed annually for inflation; this information is released no later than the preceding June 1st.

<table>
<thead>
<tr>
<th>Maximum Out-of-Pocket Limit</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-only coverage</td>
<td>$6,450</td>
<td>$6,550</td>
</tr>
<tr>
<td>Family coverage</td>
<td>$12,900</td>
<td>$13,100</td>
</tr>
</tbody>
</table>

The maximum out-of-pocket limit includes deductibles, coinsurances and copayments and is also indexed annually for inflation; non-covered expenses by the health plan do not count towards the out-of-pocket limit.

b. Your HSA-qualified HDHP offers first dollar coverage for many preventive care services, meaning that certain preventive care services are not subject to the deductible, coinsurances and copayments. Preventive care services may include: periodic health evaluations such as annual physicals, screening services like mammograms, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, and obesity weight loss programs. Check with your health plan provider for specifics;

c. Prescription drugs taken to prevent the onset of a condition for which a person has developed risk factors may be considered preventive care, thus potentially allowing copayments to apply to preventive care, rather than being subject to the deductible;

d. As a general rule of thumb, if you are treating an existing illness or condition with either a drug or procedure, that drug or procedure is not considered preventive care (an already existing condition cannot be prevented). If you are trying to stave off an illness or condition by taking a drug or with a procedure, that may be considered preventive care. Some drugs, such as cholesterol lowering ones, can be either preventive or non-preventive under HSA rules, depending on your own health situation;

e. Higher out-of-pocket (deductibles, coinsurances and copayments) may be incurred for out-of-network care. Consider this when selecting your health plan provider;

f. Effective January 1, 2006, prescription drug coverage before the deductible is met is no longer allowed, unless the prescription drug use is preventive.

3. You cannot be covered by any other health insurance that reimburses you for health expenses you incur, unless it is another HSA-qualified HDHP. If a family has all its members covered under two HSA-qualified HDHPs, or some family members are on one qualified plan and the other family members are under another qualified plan, the maximum annual contribution to the account remains in force. Just because you have coverage with two HSA-qualified HDHPs does not mean you can double your HSA contribution.

4. For those covered by two HSA-qualified HDHPs, it is a violation of the coordination of benefit rules to be paid by each plan for the same expense.
5. Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) may make you ineligible for an HSA unless they are: (1) “limited purpose” (limited to dental, vision, child care, or preventive care) or (2) “post deductible” (pay for medical expenses after the plan deductible is met). HRAs that set aside money only for retiree health expenses are also acceptable as are ones that are suspended.

6. An employer can restrict the type of expenditures an employee makes from their FSA during a two and a half month grace period that some employers may grant to employees for relief from the FSA “use-it-or-lose-it” rule. If an employer restricts the FSA expenditures to non-health items (such as is the case with a limited purpose FSA) during this grace period, then such employee is eligible for an HSA, provided they have the proper high deductible health plan.

7. If you are enrolled in Medicare or Medicaid, you cannot open an HSA.

8. Tricare (military healthcare) does not currently offer an HSA-qualified HDHP. Therefore, if you are on Tricare, you cannot have an HSA.

9. If you have received any Veterans Administration health benefits in the last three months, you cannot have an HSA.

10. If you are Medicare eligible and are not enrolled in Medicare, you can open or contribute to an HSA if you have an HSA-qualified HDHP (please see Table B).

11. You cannot establish separate HSA accounts for your minor dependent children.

12. If an adult child (up to age 26) is covered by the family HDHP, but does not qualify as a tax dependent, then the adult child can open his/her own HSA as long as he/she meets all other HSA eligibility requirements. If the adult child is claimed on the parents taxes then the parental HSA can be used for the child's qualified medical expenses.

13. You do not have to have earned income from employment to have an HSA.

14. Unlike an IRA, there are no income limits to having an HSA.

15. You do not have to itemize your deductions on your federal income taxes to deduct your contributions to an HSA. HSA deductions are “above-the-line” before Adjusted Gross Income (AGI) is calculated.

16. You can open an HSA and also have specific disease or illness, accident, disability, dental care, vision care, and long-term care insurance, and be enrolled in Employee Assistance, disease management, drug discount, and wellness programs.

NOTE: Reasonable benefit designs (lifetime limits on benefits, limits to usual, customary and reasonable amounts, limits on specific benefits, pre-certification requirements) are not counted toward the out-of-pocket maximum.
HSA Contribution Rules

1. You must have an HSA-qualified HDHP to open or contribute to an HSA.

2. If you no longer have an HSA-qualified HDHP, you cannot contribute to your HSA, but you can maintain and spend the already deposited funds as stipulated by law.

3. Beginning in 2007, the maximum HSA contribution is not limited to the annual deductible under the HDHP. Prior to 2007, your annual HSA deposit could never exceed your insurance plan’s deductible, unless you were 55 or older and were making “catch-up” contributions.

4. Maximum Contribution Per Year

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-only coverage</td>
<td>$3,350</td>
<td>$3,350</td>
</tr>
<tr>
<td>Family coverage</td>
<td>$6,650</td>
<td>$6,750</td>
</tr>
</tbody>
</table>

The maximum amount you can contribute per year is indexed annually for inflation and excludes “catch-up” contributions for those 55 years and older.

5. Beginning in 2007, as long as you are enrolled in an HSA-qualified HDHP for at least the last full month of the year, you are eligible to make a full HSA contribution for that year, provided that you remain enrolled in an eligible HDHP for the full following calendar year. If you do not have coverage at the end of the following calendar year, the maximum contribution amount is prorated based on the number of full months you had the HDHP.

For example, let’s say you become eligible on December 1, 2015. Even though you did not have HDHP coverage for the first 11 months of the year, you are still eligible to make a full year HSA contribution of $3,350 for a single under 55 and family is $6,750, provided that you maintain HDHP coverage for a period beginning December 1, 2015, and ending December 31, 2016.

6. Deposits to an HSA must be made in cash or through a rollover from a Individual Retirement Account (IRA) or another HSA.

7. For IRA rollovers, a direct trustee-to-trustee transfer can be made only one time per lifetime (the only exception being if a contributing individual goes from having self-only to family coverage during the tax year). The amount that can be distributed from the IRA and contributed to an HSA is limited to the otherwise maximum deductible contribution amount to the HSA based on the type of coverage under the HDHP at the time of the contribution. Amounts distributed from an IRA under the provision are not includible in income to the extent they would otherwise be includible in income and are not subject to the 10 percent additional tax on early distributions. The provision does not apply to simplified employee pensions (SEPs) or to SIMPLE retirement accounts.
8. Individuals 55 and older can make additional “catch-up” contributions until they enroll in Medicare. For a schedule of the increasing “catch-up” deposit amounts allowed, please see Table B.

9. In the year you enroll in Medicare, you must prorate your “catch-up” contribution for the number of months you had HSA-qualified HDHP coverage, prior to the month your Medicare enrollment is effective.

10. If you have a family plan with multiple per person deductibles, you cannot deposit more into the HSA than the maximum amount allowed for family coverage. For example, a family of two with a $4,000 per person deductible cannot deposit $8,000 into their 2014 family HSA; rather, the maximum contribution is $6,750.

11. You can “front load” or fully fund your HSA on day one of your HSA being in effect, provided you do not exceed the annual maximum amount. You can make the deposit anytime after your HSA is open.

12. If you become covered by a HDHP in a month later than January, you can “back load” or make full contributions for the preceding months up to January. If, however, you fall out of qualifying insurance coverage (for reasons other than death or disability), all the back loaded months of HSA contributions for which you are not eligible are includible in your gross income and you face a 10 percent additional tax to the amount includible.

13. You can deposit funds into your HSA in a lump sum or in any amounts or frequency you wish. However, your account trustee/custodian can impose minimum deposit and balance requirements.

14. Rollovers from an Archer Medical Savings Account (MSA) into a HSA are allowed if completed within 60 days of withdrawing the funds from your Archer MSA.

15. The term “rollover” has several meanings. Rollover of HSA funds from year to year of unspent balances is well understood. However, IRA and HSA rollovers have another meaning to the IRS: you are allowed to take any amount of your HSA funds out of your account out once a year, and there is no limitation on what those funds can be spent on. If the funds are returned to the HSA within 60 days, there is no tax or penalty. However, if those funds are not returned to the HSA within 60 days, then you must pay the taxes due on those funds, and the 20 percent penalty.

16. Unlimited HSA trustee to HSA trustee transfers are allowed, meaning you can move your HSA account any number of times you want in a given year.

17. If you have contributed an amount into your HSA which exceeds your maximum allowable deposit, you may withdraw the excess amount and any earnings on the excess amount prior to April 15th of the following year without paying a tax penalty. However, you must pay income tax on your excess contributions and income tax on any earnings of the excess contribution.
18. If you do not withdraw the excess contribution to your HSA prior to April 15th of the following year, you must pay a 6 percent excise tax on the excess contribution, and on any earnings of the excess contribution. If in the next year you decreased your maximum contribution by the amount of your excess contribution made the year before, you do not have to pay the 6 percent excise tax again. If, however, you leave the excess contribution in, and do not decrease your maximum contribution by the amount of your excess contribution made the year before, you will have to pay the 6 percent excise tax each year the excess contributions and earnings are in the HSA.

19. If your employer is paying COBRA for you, your employer does not have to continue making deposits into your HSA. However, your employer does have to pay the continuing premium for your qualified HDHP.

**HSA Spending Rules**

1. There is a wide range of allowable tax-free HSA expenditures, including vision and dental expenses, and, for example, braces for your children. A description of eligible HSA expenditures can be found in IRS Publication 502, and is located at the web at: www.irs.gov/pub/irs-pdf/p502.pdf. Publication 502 has great examples, but it is not the definitive list (please see Table D for a partial list of allowable tax-free expenditures and Table E for non allowable expenditures).

2. If a distribution from your HSA is used for purposes other than a qualified medical expense as defined in IRS Publication 502, then the amount withdrawn is subject to both income tax and a 20 percent penalty, unless the person who makes such a withdrawal from their HSA is over the age of 65. If 65 years old or older, the amount withdrawn for non medical purposes is treated as retirement income, and is subject to normal income tax, but is not subject to the 20 percent penalty.

3. Withdrawals that were made for what the HSA owner thought were qualified medical expenses, but turned out not to be qualified medical expenses, can be returned to the HSA if there is clear and convincing evidence that the expenditure was a mistake of fact. Such repayment to the HSA must be made on or before April 15th of the year following when the individual knew, or should have known, the expenditure was a mistake.

4. Other qualified expenses from an HSA include out-of-pocket healthcare expenses while enrolled in Medicare (including Medicare premiums, deductibles, coinsurance and co-pays but not “Medigap”), employee share of health insurance premiums for employer based coverage (for employees over age 65 only), premiums for COBRA continuation health insurance coverage from a former employer, premiums for qualified long-term care insurance coverage subject to the age limits in the Internal Revenue Code (please see Table C), and medical services provided in other countries.
5. Everyone with an HSA must keep all their receipts showing their expenditures from their account. There are two key reasons to do this: (1) if you exceed your deductible, you may need the receipts to send to your insurer, and (2) in case you are audited by the IRS, you need to explain your HSA expenditures.

6. You may use funds from your HSA to reimburse expenses from a previous year, but only if you had an HSA at the time the expenses were incurred.

7. Your spouse will inherit your HSA upon your death, unless you provide otherwise.

8. Should the HSA owner have no spouse, the funds in the account shall no longer be treated as an HSA but part of the individual’s estate and will be subject to estate taxes.

9. HSA funds cannot be used to pay for health insurance premiums unless the individual is receiving federal or state unemployment benefits.

Why HSAs Were Designed this Way

1. Why can’t the out-of-pocket amount be tied to the maximum contribution?
   Tying the maximum contribution rate to the out-of-pocket maximum is a viable policy, but the cost to the Federal government in lost taxable income made that idea politically unviable when the law was passed.

2. Why not carve out prescription drugs and allow tiered co-pays?
   Including prescription drugs as a benefit below the deductible will drive up the low cost of HSA-qualified HDHPs, and, as a result, reduce the amount of savings derived from switching to an HDHP. Likewise, tiered co-pays, or any other benefit that is paid outside the deductible, greatly diminishes the effect of consumers spending their own money. When you spend your own money, you spend it more frugally than if you are spending someone else’s money.

3. Why can’t early retirees pay their HSA-qualified health insurance premium from their HSA?
   This change in the law was suggested but the objection is that given that there are millions in the individual market who have health insurance but receive no tax break for their purchase, why should insured early retirees get special treatment?

4. Why can’t seniors use their HSA to pay for Medigap coverage?
   The guiding principle of HSAs is for people to use their own money to meet a substantial deductible, thereby providing a financial incentive to spend the funds wisely and not to over consume. The main purpose of a Medigap policy is to insure the Medicare deductible.

   Allowing HSA funds to pay for Medigap insurance would be akin to allowing HSA funds to buy insurance to cover the HSA deductible. In other words, it would be using HSA funds to defeat the entire purpose of an HSA.
5. **Why are the long-term care premium amounts that can be paid out of an HSA limited?**
   During the HSA legislation drafting process, there were other issues being negotiated that needed political capital more than allowing for unlimited amounts to be spent on long-term care premiums.

6. **Why can’t HSA distributions be tax-free upon your death?**
   The revenue loss to the Federal government made the price tag for that suggestion too high.

7. **Why can’t we have one joint HSA and still make “catch-up” contributions?**
   There can be only one primary account holder of the HSA. Both spouses may contribute. The practical effect of this restriction is not significant.

8. **Are “catch-up” contributions prorated when you turn 55 and 65?**
   Please see Table B.

9. **If I am self employed, can I contribute on a pre-tax basis?**
   How about for partnerships or for S corporation owners who own more than 2 percent or for LLC owners? Self-employed can only take an above-the-line deduction for their premium and HSA contribution. Regardless of how your S corporation or LLC is structured, the only way you can structure your HSA contributions is as an above-the-line deduction. The HSA legislation simply cited current law in this regard. It was a political impossibility in the HSA legislation to make the necessary change in law to allow pre-tax contributions for LLC owners, S corporation owners or the self-employed. For further guidance for partnerships and S corporations, see IRS Guidance 2005-8 at http://www.irs.gov/pub/irs-drop/n-05-08.pdf

10. **What is an “above-the-line” deduction?**
   An above-the-line deduction reduces your Federal taxable income dollar for dollar by the amount you contribute. You do not have to itemize to claim this deduction. For example, if you contribute $1,000 to your HSA, you reduce your Federal taxable income by $1,000.

11. **Why can’t I pay my health insurance premiums with my HSA?**
    The money in your HSA is designed to meet your healthcare expenses below your deductible, not to meet your health insurance premiums. What if people spent their entire HSA deposit on their insurance premiums, and found no funds left to meet their healthcare costs to meet their deductible? The only time you are allowed to pay the health insurance premium with your HSA funds is if you are collecting Federal or State unemployment benefits or are on COBRA.

12. **Can you provide a list of qualified medical expenses?**
    See Tables D and E for a list of allowable and non allowable medical expenses. Please also see IRS Publication 502, which can be found in the U.S. Treasury section of this website, or at www.irs.gov/pub/irs-pdf/p502.pdf.
Table A
Allowable HSA Investments

<table>
<thead>
<tr>
<th>Allowable HSA Investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Accounts</td>
</tr>
<tr>
<td>Annuities</td>
</tr>
<tr>
<td>Certificates of Deposit</td>
</tr>
<tr>
<td>Stocks</td>
</tr>
<tr>
<td>Bonds</td>
</tr>
<tr>
<td>Mutual Funds</td>
</tr>
<tr>
<td>Certain types of Bullion or Coins</td>
</tr>
</tbody>
</table>

NOTE: Your HSA custodian or trustee may restrict certain types of investments.

Table B
Allowable “Catch-Up” Contributions

<table>
<thead>
<tr>
<th>Allowable HSA Investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Year 2004</td>
</tr>
<tr>
<td>Tax Year 2005</td>
</tr>
<tr>
<td>Tax Year 2006</td>
</tr>
<tr>
<td>Tax Year 2007</td>
</tr>
<tr>
<td>Tax Year 2008</td>
</tr>
<tr>
<td>Tax Year 2009 and Beyond</td>
</tr>
</tbody>
</table>

Each spouse age 55 or older can contribute up to the maximum “catch-up” amount. If you did not have HDHP coverage for the full year, you must prorate your “catch-up” contribution for the number of full months you were “eligible”, i.e., had HDHP coverage. If you had HSA-qualified HDHP coverage for the entire year, you can deposit the entire “catch-up” amount starting with the year you turn 55, regardless of when you turn 55 during the year. If both spouses want to make “catch-up” contributions, each spouse must have a separate HSA.

In the year you enroll in Medicare, you must prorate your “catch-up” contribution for the number of months you had HSA-qualified HDHP coverage, prior to the month your Medicare enrollment is effective. You can delay enrollment in Medicare Part A only if you delay taking Social Security. You can delay taking Social Security up until age 70 and one half years old.
Once either spouse enrolls in Medicare, that spouse can no longer contribute any funds, including “catch-up” amounts, to their HSA. If you are not enrolled in Medicare, you can contribute to your HSA and continue to make “catch-up” contributions.

**Table C**

**Allowable Expenditures on Long-Term Care Insurance**

In order to spend money from your HSA on long-term care, your long-term care insurance contract must:

1. Be guaranteed renewable;

2. Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed;

3. Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract, must be used only to reduce future premiums or increase future benefits;

4. Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes per diem or other periodic payments without regard to expenses.

The amount of qualified long-term care premiums that can be paid from an HSA is limited. Beginning in 2006, the below amounts can be included as a qualified medical expense. These amounts may be adjusted annually for inflation. For 2016, these inflation adjusted amounts, as published in IRS Publication 502, are:

<table>
<thead>
<tr>
<th>Age 40 or Under</th>
<th>Up to $370</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 41 to 50</td>
<td>Up to $700</td>
</tr>
<tr>
<td>Age 51 to 60</td>
<td>Up to $1,400</td>
</tr>
<tr>
<td>Age 61 to 70</td>
<td>Up to $3,750</td>
</tr>
<tr>
<td>Age 71 or Over</td>
<td>Up to $4,660</td>
</tr>
</tbody>
</table>

**Table D**

**Allowable Expenditures from Your HSA**

There have been thousands of cases involving the many nuances of what constitutes “medical care” for purposes of section 213(d) of the Internal Revenue Code. A determination of whether an expense is for “medical care” is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. The determination often hangs on the word “primarily”.

**NOTE:** If you are receiving federal or state unemployment insurance, you may pay for your health insurance premiums out of your HSA. See next page for a list of allowable expenditures.
<table>
<thead>
<tr>
<th>Allowable Expenditures from Your HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Ambulance</td>
</tr>
<tr>
<td>Artificial Teeth</td>
</tr>
<tr>
<td>Birth Control Pills (by prescription)</td>
</tr>
<tr>
<td>Car Special Hand Controls (for disability)</td>
</tr>
<tr>
<td>Chiropractors</td>
</tr>
<tr>
<td>COBRA premiums</td>
</tr>
<tr>
<td>Cosmetic Surgery (if due to trauma or disease)</td>
</tr>
<tr>
<td>Dental Treatment</td>
</tr>
<tr>
<td>Diagnostic Devices</td>
</tr>
<tr>
<td>Drug Addiction Treatment (inpatient)</td>
</tr>
<tr>
<td>Eyeglasses</td>
</tr>
<tr>
<td>Guide Dog</td>
</tr>
<tr>
<td>Health Institute (if prescribed by physician)</td>
</tr>
<tr>
<td>Hearing Aids</td>
</tr>
<tr>
<td>Hospital Services</td>
</tr>
<tr>
<td>Lasik Surgery</td>
</tr>
<tr>
<td>Learning Disability Fees (prescription)</td>
</tr>
<tr>
<td>Life Care Fees</td>
</tr>
<tr>
<td>Long-Term Care (medical expenses)</td>
</tr>
<tr>
<td>Meals (associated with receiving treatments)</td>
</tr>
<tr>
<td>Medicare Premiums</td>
</tr>
<tr>
<td>Nursing Care</td>
</tr>
<tr>
<td>Obstetrician</td>
</tr>
<tr>
<td>Operations - Surgical</td>
</tr>
<tr>
<td>Optician</td>
</tr>
<tr>
<td>Organ Transplant (including donor’s expenses)</td>
</tr>
<tr>
<td>Orthopedic Shoes</td>
</tr>
<tr>
<td>Osteopath</td>
</tr>
<tr>
<td>Over-the-Counter Medicines (only with a prescription)</td>
</tr>
<tr>
<td>Pediatrician</td>
</tr>
<tr>
<td>Podiatrist</td>
</tr>
<tr>
<td>Prenatal Care</td>
</tr>
<tr>
<td>Prosthesis</td>
</tr>
<tr>
<td>Psychiatric Care</td>
</tr>
</tbody>
</table>
Psychoanalysis
Psychologist
Radium Treatment
Special Education for Children (ill or disabled)
Spinal Tests
Sterilization
Telephones and Television for the Hearing
Therapy
Treatment
Vitamins (if prescribed)
Wheelchair
X Rays

<table>
<thead>
<tr>
<th>Psychoanalyst</th>
<th>Psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>Qualified Long-Term Care Services</td>
</tr>
<tr>
<td>Smoking Cessation Programs</td>
<td>Specialists</td>
</tr>
<tr>
<td>Splints</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Transportation Expenses for Health Care</td>
<td>Vaccines</td>
</tr>
<tr>
<td>Weight Loss Programs</td>
<td>Wig (hair loss from disease)</td>
</tr>
</tbody>
</table>

### Table E
#### Non-Allowable Expenditures from Your HSA

<table>
<thead>
<tr>
<th>Non-Allowable Expenditures from Your HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Payment for Future Medical Expenses</td>
</tr>
<tr>
<td>Automobile Insurance Premium</td>
</tr>
<tr>
<td>Boarding School Fees</td>
</tr>
<tr>
<td>Commuting Expenses for the Disabled</td>
</tr>
<tr>
<td>Cosmetics and Hygiene Products</td>
</tr>
<tr>
<td>Diaper Service</td>
</tr>
<tr>
<td>Electrolysis or Hair Removal</td>
</tr>
<tr>
<td>Hair Transplant</td>
</tr>
<tr>
<td>Household Help</td>
</tr>
<tr>
<td>Illegally Procured Drugs</td>
</tr>
<tr>
<td>Medigap premiums</td>
</tr>
<tr>
<td>Premiums for Life or Disability Insurance</td>
</tr>
<tr>
<td>Premiums for your HSA-qualified health plan</td>
</tr>
<tr>
<td>Social Activities</td>
</tr>
<tr>
<td>Swimming Lessons</td>
</tr>
<tr>
<td>Travel for General Health Improvement</td>
</tr>
</tbody>
</table>

If you have questions regarding your account, call the number on the back of your Blues ID or Healthy Blue HSA card.
Section 6: Your Health Care Benefits

This section of your handbook explains the benefits provided by your PPO health care plan. These benefits include coverage for your hospital care and the services you receive from a physician. Unless otherwise indicated, all benefits in this section are subject to your coverage’s deductibles, coinsurances, copayments and benefit maximums.

Medical Necessity
A service that you receive from a medical provider must be medically necessary in order to be payable under your health care plan. The guidelines for determining medical necessity are specified in detail in the “Glossary of Health Care Terms” section of this handbook.

In some cases, you are 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 BCBS member either at the time of admission or within 30 days after you are discharged
- When you fail to provide the hospital with information that identifies your coverage

Your Out-of-Pocket Costs
For most covered services, you are required to pay a portion of the approved amount through deductibles, coinsurances and copayments. See the chart below for your out-of-pocket cost requirements and BCBS payment percentages for covered services for the plan option you have elected.

Benefit Period
A benefit period is based on a calendar year beginning Jan. 1 and ending Dec. 31. Your first benefit period may be shorter, depending on your employment date and when you become eligible for coverage.

Deductible
Deductible is a specified amount that you are required to pay for covered services during each benefit period before benefits are paid by your plan.

The full family deductible must be met under a two person or family contract before benefits are paid for any member on the contract.

Copayment
Copayment is a flat dollar amount you must pay for eligible services. When a copayment is charged for a service, it may also be subject to an additional coinsurance.
Coinsurance
Coinsurance is the percentage of the approved amount you must pay for eligible services once you have met your deductible requirements.
## Benefits-at-a-Glance

<table>
<thead>
<tr>
<th>Deductible, Copays, Coinsurance and Dollar Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong> - per calendar year</td>
<td>$1,300 per member</td>
<td>$2,500 per member</td>
</tr>
<tr>
<td></td>
<td>$2,600 per family</td>
<td>$5,000 per family</td>
</tr>
<tr>
<td>The full family deductible must be met under a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>two person or family contract before benefits are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>paid for any person on the contract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fixed Dollar Copays</td>
<td>No Copay</td>
<td>No Copay</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Percent Coinsurance</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The full family out of pocket maximum must be meet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>before it is considered satisfied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Maintenance Exam - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Physical Related Test X-Rays, EKG and</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>lab procedures performed as part of the health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maintenance exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Gynecological Exam - two per calendar year,</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>in addition to health maintenance exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap Smear Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammography Screening - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Contraceptive Methods and Counseling</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Screening - one</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopic Exams - one per calendar year</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 8 visits, birth through 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits, 13 months through 23 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 visits, 24 months through 35 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 visits, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits beyond 47 months are limited to one per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>member per calendar year under the health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maintenance exam benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations- pediatric and adult</td>
<td>Covered - 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Physician Office Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Office Consultation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Pre-Surgical Consultation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Medical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Qualified medical emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency use of the Emergency Room</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Ambulance Services - Medically Necessary Transport</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>MRI, MRA, PET and CAT Scans and Nuclear Medicine</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Laboratory &amp; Pathology</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maternity Services Provided by a Physician</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care Visits</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Postnatal Care Visits</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hospital Care</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Alternatives to Hospital Care</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Limited to a maximum of 90 days per calendar year</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 100% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Surgical Services</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (includes related surgical services)</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Sterilization - males only; excludes reversal sterilization</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Sterilization - females only; excludes reversal sterilization</td>
<td>Covered - 100%</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Human Organ Transplants</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Organ Transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)</td>
<td>Covered - 100% after deductible</td>
<td>Not covered except in designated facilities</td>
</tr>
<tr>
<td>Kidney, Cornea, Bone Marrow and Skin</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Behavioral Health Care and Substance Abuse Treatment Services</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Behavioral Health Care and Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Care and Substance Abuse Treatment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Behavioral Analysis (ABA) 30 units (7.5 hrs per week) birth through age 6</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>24 units (6 hrs per week) age 7 - 12</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>18 units (4.5 hrs per week) age 13 - 18</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 24 visits per calendar year</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Covered - 80% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapy Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
<tr>
<td>Limited to a combined maximum of 60 visits per calendar year</td>
<td>Covered - 100% after deductible</td>
<td>Covered - 80% after deductible</td>
</tr>
</tbody>
</table>

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing. This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control. BCBSM provides administrative claims services only. Your employer is financially responsible for claims.
Hospital Benefits — Inpatient Care
For an approved hospital admission, your plan will cover the following inpatient hospital services. All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

Precertification of Hospital Admissions
Precertification is required for all inpatient hospital admissions. A precertification review determines if a hospital admission or service is appropriate. This process eliminates unnecessary inpatient hospital care and determines an appropriate length of stay for an admission. Approval of an admission does not guarantee payment. Please make sure that you and your provider confirm your coverage limitations or exclusions.

Room and Board
Your benefits include the cost of a semi-private room; the use of special units such as intensive, burn, or cardiac care; meals and special diets; and general nursing care. However, the cost of a private room is not covered. If you request a private room, your coverage will pay the cost of a semi-private room, and you must pay the difference.

General Medical Care
You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. The following types of admissions are considered general medical care:

- **Maternity and nursery care** — Coverage for obstetrical and maternity care includes delivery room costs and ordinary nursery care. Refer to the eligibility section for guidelines on adding dependents. Your benefits include coverage for medically necessary termination. Maternity services are covered for dependents.

- **Cosmetic surgery** — Admissions for cosmetic and reconstructive surgery are covered for the correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.

- **Dental surgery** — Admissions for dental surgery are covered for the removal of impacted teeth or multiple extractions only when a concurrent hazardous medical condition, such as a heart condition, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Behavioral Health Care and Substance Abuse Treatment
You have coverage for inpatient behavioral health care and inpatient substance abuse treatment in a BCBS-approved facility. Benefits are also available when services are provided in BCBS-approved day- and night-care centers.

Care provided during a behavioral health and substance abuse treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility. Includes coverage for Acute Care Hospital and Residential Treatment Facility.
Fully licensed psychologists with hospital privileges can be directly reimbursed for the following inpatient services:

- Psychological testing
- Individual psychotherapeutic treatment
- Family counseling for members of a patient’s family
- Group psychotherapeutic treatment
- Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your behavioral health condition

**Important:** Inpatient behavioral health care and substance abuse treatment admissions are covered only if they meet BCBS severity of illness and intensity of service criteria. The physician must call BCBSM Behavioral Health Manager to attain authorization for service (s) rendered.

**Psychiatric Residential Treatment**
Your coverage may include psychiatric residential treatment.

Psychiatric residential treatment allows people who are suffering from a psychiatric illness, such as anorexia nervosa, schizophrenia or bipolar disorder, to receive around-the-clock care.

Treatment takes place in a state-licensed facility (for example, an adult or child foster care facility) with a multidisciplinary treatment team. Here’s what’s available at the facility to help with psychiatric issues, administration of medication and crisis intervention as needed:

- Patient supervision 24/7
- Nursing care on-site, or on call no more than 15 minutes away, 24/7
- A psychiatrist on call 24/7
- A psychiatrist on-site at least two days each week.

To find out if you have the benefit for psychiatric residential treatment, call the Customer Service number on the back of your Blue Cross ID card. If you have the benefit, a customer service representative can help you find facilities. Be sure to ask your doctor or other health care professional if psychiatric residential treatment is right for you or your family member. Your doctor can arrange your treatment with the appropriate facility. The facility must obtain pre-authorization for your treatment to be covered.

**Hospital Services and Supplies**
The following services and supplies are covered when they are needed during a hospital admission:

- **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service
- **Blood services** — Includes blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood
• **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service

• **Drugs** — Includes medicines prescribed and given during a hospital admission

• **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay

• **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the hospital admission

• **Prosthetic and orthotic appliances** — Includes items that are surgically implanted in the body, such as heart valves

• **Special care units** — Includes operating, delivery and recovery rooms

Your coverage includes the following diagnostic and radiology services:

• **CAT and MRI scans** — Covers scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBS

• **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury

• **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy

• **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an illness or injury

**Hospital Benefits — Outpatient Care**
The following services are covered when performed in the outpatient department of a participating hospital or, where noted, in a freestanding facility approved by BCBS. All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

**Emergency Room Care**
You are covered for the treatment of accidental injuries or conditions that BCBS determines are medical emergencies. If you’re not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it’s best to call your doctor or your doctor’s after hours phone number.

• **An accidental injury** is physical damage caused by an action, object, or substance from outside of the body. This includes strains, sprains, fractures, cuts and bruises; allergic reactions, frostbite, sunburn and sunstroke; swallowing poisons and medication overdosing; and inhaling smoke, carbon monoxide or fumes.

• A **medical emergency** is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.
Preadmission Testing
Preadmission testing is covered when performed in the outpatient department of a hospital within seven days of a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.

Physical, Occupational and Speech Therapy
Physical, occupational and speech therapy services are payable when provided in:

- The outpatient department of a participating hospital
- A participating outpatient therapy facility
- A physician's office

In addition, physical therapy services are payable in the offices of independent licensed therapists and chiropractors office.

Important: Payment for therapy is based on the diagnosis and the location. Ask your physician or therapist to call BCBS to verify if the treatment meets diagnosis requirements, and if the prescribed therapy will be rendered in a payable location before receiving therapy treatment.

Therapy must:

- Be prescribed by the patient's attending physician
- Require the assistance and supervision of the appropriate licensed therapist
- Be designed to improve or restore the patient’s functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered therapy are:

- Physical therapy prescribed to restore the musculoskeletal functioning of legs
- Physical therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints
- Speech and language pathology services to treat severe congenital or developmental disorders. These disorders must meet objective guidelines for the assessment of severity (see Speech Pathology Severity Guidelines in the "Glossary of Health Care Terms" section), or generally accepted standards of practice. Additionally, treatment plans for these conditions must contain measurable treatment goals that providers regularly assess. Progress toward goals must be documented in the clinical record in order for coverage to continue.

Your coverage does not pay for:

- Long-standing, chronic conditions such as arthritis
• Health club membership or spa membership
• Inpatient hospital admissions principally for speech or language therapy

**Autism Spectrum Disorders**
We pay for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as described below.

**Diagnostic services** must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations, or tests, including the autism diagnostic observation schedule.

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

• Behavioral health treatment includes evidence-based treatment programs such as applied behavior analysis. Applied behavior analysis services must be provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.

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

**Applied behavior analysis services are covered subject to the following requirements:**

**Behavioral health treatment**– It includes evidence-based counseling that must be provided or supervised by a licensed psychologist, so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.

**Psychiatric care**– It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

**Psychological care**– It includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.

**NOTE:** Benefits for autism disorders are in addition to any psychiatric, psychological, and non-applied behavior analysis benefits may be available under the plan.

**Therapeutic care**– It includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.
Coverage Requirements

All autism services and treatment must be:

- Medically necessary
- Comprehensive and focused on managing and improving the symptoms directly related to a member’s Autism Spectrum Disorder.
- Deemed safe and effective by BCBS.
Limitations and Exclusions
In addition to those listed in this handbook, the following limitations and exclusions also apply:

- Benefits for autism disorders are limited to (children through the age of 18). This age limitation does not apply to psychiatric, psychological and non-applied behavior analysis services and services used to diagnose autism.
- All autism benefits including, but not limited to, medical-surgical services and/or behavioral health treatment covered under this plan are subject to any hospital/medical deductibles, coinsurance and copayments imposed under this plan.
- Occupational therapy, physical therapy and speech and language pathology services for treatment of autism are subject to the visit limitations that apply to these services.
- Any treatment that is not a covered benefit by BCBSM, including, but not limited to, sensory integration therapy and chelation therapy will not be paid.
- Conditions such as Rett’s Disorder and Childhood Disintegrative Disorder are not payable under this plan.
- When a member is treated with approved services for covered autism disorders, coverage for the services under this autism benefit overrides certain exclusions in your plan such as the exclusion of:
  - Experimental treatment
  - Treatment of chronic, developmental or congenital conditions
  - Treatment of learning disabilities or inherited speech abnormalities
  - Treatment solely to improve cognition, concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.
- All autism services must be provided by professional providers who are registered with BCBS as a participating or non-participating provider.

Cardiac Rehabilitation
You have coverage for cardiac rehabilitation services. This benefit is payable if it is provided:

- In a hospital-based or freestanding (not owned or operated by a hospital) cardiac rehabilitation center
- By a licensed physician (M.D. or D.O.) or professionals working under the direct supervision of a licensed physician
- Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery
- For physician prescribed exercises to cardiac patients during phase II of their cardiac rehabilitation treatment
- Within the 12 week total time allowed for cardiac rehabilitation

Phase II services include:
Six-week program that follows inpatient admission or outpatient services for a heart condition
• Complete medical history
• Stress test with electrocardiogram monitoring
• Lipid profile
• ECG
• Three exercise sessions per week
• Nutrition and risk factor recognition classes

Note: Patient education services and ECG testing are not covered as separately identifiable services when reported as part of cardiac rehabilitation.

Outpatient Behavioral Health Care
Your coverage includes psychological testing, individual and group therapy sessions and family counseling when provided through an approved facility, by a physician or by a fully licensed psychologist.

Outpatient Substance Abuse Treatment
Your coverage includes outpatient substance abuse treatment provided at an approved substance abuse treatment facility.

Additional Hospital Services and Programs
Your coverage will pay the approved amount for the following services provided by a participating hospital or an approved facility, as indicated below. All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

Chemotherapy
You may receive chemotherapy treatment in a hospital, in the outpatient department of a hospital or in a physician's office.

Benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy and provided as part of a chemotherapy program, if the treatment is not considered experimental or investigative. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

Hemodialysis
Hemodialysis services to treat acute renal (kidney) failure and end stage renal disease are a benefit. Treatment may take place in the outpatient department of a hospital, in a licensed facility or in the home. Home hemodialysis must be arranged by a physician and services must be billed by a participating hospital that has an approved hemodialysis program. Coverage includes the cost of the equipment, installation, training and necessary hemodialysis supplies.
Note: Dialysis services for the treatment of End Stage Renal Disease ("ESRD") are coordinated with Medicare. It is important for individuals with ESRD to apply for Medicare coverage regardless of age. BCBS is the primary payer for up to 30 months if the member is under 65 and is eligible for Medicare solely because of ESRD.

Home Hemophilia Program
The Home Hemophilia Program provides benefits for the necessary medications and supplies used to treat hemophilia in a home setting. All medications and supplies needed for the patient to self-infuse at home, including syringes, needles and the antihemophilic factor, must be supplied by a participating hospital. Benefits may also include training to the patient or a family member on how to inject the antihemophilic factor, when the training is provided through a participating hospital. Services are coordinated through the Individual Case Management Program and may not be subject to deductibles, coinsurances and copayments.

Home Health Care
Your benefits include home health care visits when the patient is referred to and accepted by a participating home health care agency. The services must be prescribed by a physician who submits a detailed treatment plan to the home health care agency and certifies that home health care is medically necessary.

Home health care benefits include nursing services; physical, occupational or speech therapy; social service and nutritional guidance, medication, supplies and lab work.

Skilled Nursing Care
A convalescent care facility provides skilled, comprehensive inpatient care for either a short or extended period of time. Your coverage includes skilled nursing care in an approved skilled nursing facility, when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. Physician benefits for medical care are limited to two visits per week.

Convalescent care benefits cannot be used for custodial care or care for mental deficiency, mental retardation, senile deterioration or cases in which the prognosis is unfavorable.

Human Organ Transplants
The following types of human organ transplants are covered when received at a participating hospital or, where noted, in a BCBS-approved transplant facility. All benefits are subject to any deductibles, coinsurances and copayments and benefit maximums detailed earlier in this section.

Organ and Tissue Transplants
Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient when performed in a participating facility. Coverage includes evaluation and surgical removal of the donated organ (including skin, cornea and kidney) from a living or non-living donor. These transplants are subject to the same guidelines as other PPO benefits.
**Bone Marrow Transplants**

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

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

**Allogeneic Transplants**

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

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

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

**Autologous Transplants**

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization
NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia
- Aplastic anemia (acquired or congenital, e.g., Fanconi’s anemia or Diamond-Blackfan syndrome)
- Beta Thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann’s syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter’s, Hurler’s, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher’s disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- Renal cell CA
- Plasmacytomas

Autologous transplants are covered to treat the following conditions:

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

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

We do not pay the following for bone marrow transplants:

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

**Oncology Clinical Trials**
Covers bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This does not limit or preclude coverage of antineoplastic drugs when state law requires that these drugs, and the reasonable cost of their administration, be covered.

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

The preapproval process allows you and your provider to know if we will cover proposed services, hospital admissions and lengths of stay in a hospital before treatment begins. If preapproval is not obtained before you receive services or are admitted to a hospital, the services, admission and length of stay will not be covered.

**NOTE:** Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur.

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

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

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 504C
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

For questions, call 1-800-242-3504

Preapproval will be granted if:

- The patient is an eligible BCBSM member
- The patient has BCBSM hospital-medical-surgical coverage
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center
- The proposed services are medically necessary
- An inpatient admission to a designated cancer center and the length of stay at the center are medically necessary (in those cases requiring inpatient treatment). A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

The services covered are payable when directly related to a transplant. The transplant must be performed at a designated cancer center or its affiliate to be a covered benefit.

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

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

**Autologous Transplants**

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

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

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

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

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

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

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

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

Your coverage does not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see the “Glossary of Health Care Terms” section for definition of medically necessary)
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor’s health care coverage will pay for such services.
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn’s umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitter or day care services, services provided by family members, reimbursement of food stamps, mail or UPS services, internet connection, and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or lengths of stay related to any of the above exclusions

**Specified Human Organ Transplants**

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is preapproved by BCBSM and received at a BCBS designated transplant facility.

- Benefits apply only to transplants of the:
  - Combined small intestine-liver
  - Heart
  - Heart-lung(s)
  - Liver
  - Lobar lung
  - Lung(s)
  - Pancreas
– Partial liver
– Kidney-liver
– Simultaneous pancreas-kidney
– Small intestine (small bowel)
– Multivisceral transplants (as determined by BCBSM)

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

When directly related to the transplant, we pay for:

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

We also pay for the following:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery. This includes:
  – Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor)

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

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

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

During the benefit period, the deductible, copayments and coinsurance may apply to the specified human organ transplants and related procedures.

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

• Services that are not BCBSM benefits
• Services rendered to a recipient who is not a BCBSM member
• Living donor transplants not listed in this benefit plan
• Anti-rejection drugs that do not have Food and Drug Administration approval
• Transplant surgery and related services performed in a nondesignated facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility unless medically necessary and approved by the BCBSM medical director
• Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
• Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greetings cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, Internet service, and entertainment (such as cable television, books, magazines and movie rentals))
• Routine storage cost of donor organs for the future purpose of transplantation
• Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this benefit plan
• Experimental transplant procedures
**Physician Benefits**
You have coverage for the physician services described below.

**Office Visits**
Your benefits include visits to a physician’s office, outpatient clinic or outpatient department of a hospital for the examination, diagnosis and treatment of general medical conditions. Services include medical care, consultations, medication and injections.

**Preventive Services**
You have coverage for the following preventive services.

- **Routine health maintenance exams**
- **Routine gynecological exam**
- **Well child care** — Your benefits include visits to a physician to monitor the development of a child.
- **Laboratory and screening services** — You have coverage for routine laboratory, diagnostic tests and X-rays related to a routine exam which include but are not limited to:
  - Chemical profile
  - Complete blood count (CBC)
  - Fecal occult blood screening
  - Urinalysis
  - Chest X-ray
  - EKG
- **Endoscopic procedures** — You have coverage for the following services, when performed as routine screening:
  - Colonoscopy
  - Sigmoidoscopy
  - Flexible sigmoidoscopy
  - Procto-sigmoidoscopy
- **Routine mammograms** — You have coverage for routine mammogram (breast X-ray) for female members. More frequent mammograms are covered as diagnostic services if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.
- **Pap smear** — You have coverage for laboratory services routine pap smear, for female members. More frequent pap smears are covered as diagnostic services for the following conditions:
  - Previous surgery for vaginal, cervical or uterine malignancy
- Presence of a suspected lesion in the vaginal, cervical or uterine areas
- Post-surgery

- **Prostate specific antigen screening** — Your coverage includes PSA screening laboratory test for male members.

- **Immunizations** — Your coverage also includes the following:
  Childhood and Adult immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act.

  Human Papilloma Virus (HPV) vaccine is covered for females and males age 9 to 26.

**Allergy Services**
Allergy testing and therapy are covered when performed by or under the supervision of a physician. Services include scratch and puncture testing, allergy survey, allergy serum and therapeutic injections.

**Chiropractic Services**
Your benefits include the following chiropractic services:

- **New patient office calls** — Covers one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office visits**
- **Chiropractic Traction** — Number of payable visits is determined by your physical therapy benefit.
- **Chiropractic Manipulation**
- **Physical Therapy**
- **X-rays**
- **Spinal and Extra-spinal manipulation**

**Maternity Care**
You have coverage for obstetrical services including delivery and pre and post-natal care visits. The initial inpatient examination of the newborn is covered when performed by a physician other than the delivering provider. Your benefits include coverage for medically necessary termination. Maternity services are covered for dependents.

**Note:** Maternity care benefits are also payable when provided by a certified nurse midwife. Delivery must be in a hospital or BCBS-approved birthing center.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn
earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Physician Emergency Care**
Emergency care benefits cover physician services for the initial examination and treatment of accidental injuries and conditions determined by BCBS to be medical emergencies. These terms are explained in the "Glossary of Health Care Terms" section.

**Inpatient Medical Care**
While you are an inpatient, you are covered for an unlimited number of medical visits by a physician for general medical conditions that are not related to surgery or maternity care.

**Inpatient Consultations**
In complicated situations, the physician in charge of the case may consult another physician for assistance or advice about diagnosis or treatment. Necessary inpatient consultations are covered when they are requested by the attending physician.

**Presurgical Consultation**
A presurgical consultation can help you obtain additional information about the benefits and risks of your proposed surgery and inform you of any alternative treatments that may be available. X-rays and laboratory services your doctor may request will be covered according to the level of benefits outlined in this handbook.

The physician's recommendation does not affect the approved amount for the surgery. Whether or not the recommendation from the second physician favors surgery, **you make the final decision about the surgery.**

**Surgery**
Surgical procedures needed for the diagnosis and treatment of diseases and injuries are covered. Surgical benefits include all related pre- and post-operative medical care by the attending surgeon.

- **Multiple surgeries** (two or more surgical procedures during one operative session) are subject to payment limitations:
  - When the surgeries are through **different** incisions, your coverage will pay the approved amount for the primary surgery (the procedure with the higher benefit payment), plus half the approved amount for any additional procedures.
  - When the surgeries are through the **same** incision, your coverage will pay the approved amount only for the primary surgery. (Physician payment for additional surgeries through the same incision is included in the amount paid for the primary surgery.)

  **Note:** Participating providers accept these approved amounts, less any required deductibles, coinsurances and copayments, for multiple surgeries as payment in full.
- **Laser surgery** is a benefit when the procedure is not considered experimental or investigative and the payment is not more than that allowed for conventional surgical procedures.

- **Breast reconstruction 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 lymphedemas

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars and for correction of deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

- **Dental surgery** for the removal of impacted teeth or multiple extractions is covered only when the patient must be hospitalized for the surgery because a concurrent medical condition exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.

- **Voluntary sterilization** for both male and female patients is covered regardless of medical necessity. Reversal procedures are not covered.

**Ambulatory Surgery Care**
Your coverage includes surgical services performed in an ambulatory surgery facility. This generally includes elective surgery that does not require the use of hospital facilities but cannot routinely be performed in an office setting.

**Technical Surgical Assistance**
Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring assistance must be an approved major surgical procedure.

**Anesthesia**
Your benefits include the administration of drugs or gases when they are necessary for a covered service, and when they are given by a physician other than the operating surgeon or an assistant, or by a certified registered nurse anesthetist. Anesthesia provided by a nurse anesthetist under the supervision of an anesthesiologist also is covered.

**Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder**
Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs) and arthrocentesis (injection procedures). However, some symptom-management services are covered, such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications) and medications.

Please note that irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change in the positioning of the jaw or a permanent alteration of the vertical
dimension. **Reversible** treatment of the mouth and jaw is *not* intended to result in permanent alteration of the bite; it is directed at managing the patient's symptoms.

Other than the exceptions noted, benefits are *not* payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint and skull and the muscles, nerves, and tissue related to the jaw joint. These exclusions include but are not limited to: crowns, inlays, caps, restorations, grinding, orthodontics, dentures, partial dentures or bridges.

If you are not sure that your prescribed treatment will be covered, ask your physician to contact BCBS for approval **before** treatment begins.

**Diagnostic and Radiation Services**

All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

- **Diagnostic radiology** — Benefits include outpatient diagnostic radiology services required for the diagnosis of an illness or injury when performed and billed by a physician. These services may be performed in the physician's office or in the outpatient department of a hospital. Covered services include ultrasound and diagnostic X-rays. MRI and CAT scans of the head and body also are covered when performed for an eligible diagnosis in approved facilities. Select services may require preauthorization.

- **Laboratory and pathology services** — Laboratory and pathology services performed in the physician's office or in the outpatient department of a hospital and ordered and billed by a physician are covered. This benefit includes laboratory and pathology tests required in the diagnosis of an illness or injury.

- **Diagnostic tests** — Diagnostic tests performed in the physician's office or in the outpatient department of a hospital are covered when performed and billed by a physician. Covered tests include EKGs, EMGs, EEGs, thyroid function tests, select sleep studies and nerve conduction studies required in the diagnosis of an illness or injury. Select services may require preauthorization.

- **Radiation therapy** — Radiation therapy performed in the physician's office or in the outpatient department of a hospital is covered when performed and billed by a physician. Covered services include radiological treatment by X-ray, isotopes, or cobalt for a malignancy.

**Additional Benefits**

Your coverage will pay the approved amount for the following additional benefits. All benefits are subject to any deductibles, coinsurances and copayments or benefit maximums detailed earlier in this section.

**Ambulance Services**

Ground and air ambulance services required because of an injury or hospital admission are covered. Services must be medically necessary and prescribed by the attending physician. The patient may be transported to and from the hospital, between hospitals, and between hospitals.
and approved medical facilities. Services must be provided by a licensed ambulance company. This benefit includes the equipment used, mileage and waiting time. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.

**Prescribed Contraceptive Devices**
Your coverage includes physician-prescribed contraceptive devices such as diaphragms and IUD or contraceptive implants designed to prevent pregnancy.

**Durable Medical Equipment**
Benefits are covered for rental or purchase (whichever is less expensive) and repair of durable medical equipment appropriate for home use and prescribed by a physician. Examples of durable medical equipment are canes, wheelchairs and walkers.

The equipment must be medically necessary for the treatment of an illness or injury or used to improve the functioning of the patient’s body. Equipment primarily for the comfort or convenience of the patient is not covered.

**Prosthetic and Orthotic Appliances**
Benefits are provided for external appliances to replace a missing part of the body or to correct any defect of form or function of the body. Benefits include temporary appliances, delivery, services and fitting charges.

These appliances must be prescribed by a physician and supplied by a fully accredited facility approved by the American Board of Certification in Orthotics and Prosthetics.

Adjustment or replacement of eligible appliances is payable only when required because of normal wear or growth or a change in the patient's condition. Examples of these appliances are braces and artificial arms and legs.

**Prosthetic Appliances Following Mastectomy**
Benefits are provided for an external breast prosthesis following a mastectomy when prescribed by a physician. Benefits cover two post-surgical forms and four surgical bras every benefit period. Replacements are payable only when required because of a significant change in body weight or when necessary for hygienic reasons.

**Oxygen and Other Therapeutic Gases**
Oxygen and equipment to administer the oxygen are covered when medically necessary and prescribed by a physician.

**Optical Services Following Cataract Surgery**
Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are not covered.
**Dental Services**
Dental services and appliances required for the treatment of an accidental injury are covered. The injury must have been caused by an external force. Injuries resulting from biting or chewing are not covered unless they are the direct result of an act of domestic violence or a mental health condition.

**Medical Supplies and Dressings**
Your coverage includes medically necessary medical supplies and dressings that are used to treat a diagnosed condition.

**Private Duty Nursing**
Private duty nursing is covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

The services must be prescribed by a physician and provided by a registered nurse or licensed practical nurse. The attending physician must complete a certification statement each month the patient is under care.

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

**Individual Case Management Program**
Individual Case Management is a voluntary program through which care is provided outside a hospital setting. The program is designed to assist an individual whose cost of medical care is very high or whose care would exhaust available benefits.

A case management analyst evaluates a patient for ICMP who has been referred by a hospital, physician or a family member. When the patient is accepted as a candidate for ICMP, an analyst works with the patient's family and physician to develop a personal treatment plan, called the alternative benefit plan. The plan is discussed with the patient, the family and the attending physician before the recommendations are finalized. The analyst explains all the benefits, resources, facilities and services that are part of the treatment plan. These can include services not normally included in your coverage. The analyst also identifies all payable services and payment arrangements related to the plan.

**Note:** Whenever possible, BCBS will identify more than one provider for services recommended in the plan. The patient and family then have the option to select the provider.
After reviewing the alternative benefit plan documents, the patient and family can decide whether or not to accept the plan. Participation is entirely voluntary.

Once the plan is implemented, participation will be canceled in either of the following situations:

- The patient's condition no longer requires the extra benefits documented in the alternative benefit plan.
- The total amount paid under the alternative benefit plan exceeds the amount that would be payable under the patient's regular facility coverage.

If you have questions about individual case management, contact your BCBS customer service representative.

**Hospice Care**
A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

Hospice benefits replace the benefits normally available under your medical coverage with benefits that are specific to the patient's needs. These may include alternative services to provide more appropriate care for the patient. However, services for medical conditions unrelated to the terminal illness are subject to the medical coverage guidelines.

You may apply for hospice benefits only after discussion with and referral by your attending physician. All hospice services must be arranged through an approved hospice provider.

**Levels of Care**
The hospice program provides four levels of care:

- **Routine home care** — Consists of services provided to patients who are living at home and are not receiving continuous home care. Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.

- **Continuous home care** — Consists of nursing care services provided to patients during crisis periods to enable them to stay in their homes. Such care must be provided for a minimum of eight continuous hours per day.

- **Inpatient respite care** — Consists of short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.

- **General inpatient care** — Consists of services for pain control and acute and chronic symptom management that cannot be provided in other less intensive settings.
PPO Exclusions and Limitations
In addition to the exclusions and limitations listed elsewhere in this handbook, unless otherwise stated, the following exclusions and limitations apply:

- The following amounts or charges may not be used to meet your out-of-pocket maximum:
  - Charges that exceed the approved amount
  - Charges for non-covered services
  - Deductible or coinsurance required under other BCBS coverage
- Care and services available at no cost to you in a veteran's, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- Custodial care, rest therapy and care in nursing or rest home facilities
- 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, such as a heart condition, exists
- Treatment of temporomandibular joint syndrome and related jaw-joint problems by any method other than as specified in this handbook
- Any medical care, hospitalization or service provided before the effective date of coverage or after the coverage termination date
- Routine hospital outpatient care requiring repeat visits for the treatment of chronic conditions such as diabetes
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests or electrocardiography
- Items for the personal comfort or convenience of the patient
- Psychiatric services after determination that the patient's condition will not respond to treatment
- Psychological tests for vocational guidance or counseling
- Routine premarital or pre-employment exams
- Prescription drugs (may be covered under an additional freestanding program)
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services provided through a medical clinic or similar facility provided or maintained by an employer
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund
- Care and services received under another plan offered by BCBSM or another BCBS plan
• Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal law requires Medicare to be secondary.

• Cosmetic surgery solely for improving appearance, except as specified in this handbook

• Treatment of a condition caused by military action or war, declared or undeclared

• 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

• Dialysis services after 30 months of end stage renal disease treatment

• Services that are not included in your employer’s coverage documents

• Charges from a non-participating provider that are in excess of the BCBS approved amount

• Charges for hospital room accommodations over and above the hospital’s regular charges covered by your medical benefits

• Transportation and travel except as specified in this handbook

• Hearing exam and preparation, fitting or procurement of hearing aids

• Eyeglasses or contact lenses and vision examinations for prescribing or fitting them (except for aphakic patients) or for soft contact lenses or sclera shells intended for use in the treatment of diseases or injury or as specified following cataract surgery

• Professional fees for injections given by anyone other than a physician

• Injections for cosmetic purposes

• Charges for examinations required by school, camp, licensing or for any other regulatory purpose

• Hospital admission for weight control

• Testing more frequently than necessary

• Dental care and dental appliances except those specified in your coverage

• Elective termination of pregnancy

• Reversal of sterilization procedures for males

• Reversal of sterilization procedures for females

• Artificial insemination, in-vitro fertilization or embryo transfer procedures

• Radial keratotomy

• Acupuncture services

• Routine podiatry services

• Non-emergent medical services received in an emergency room

• Hair prostheses such as wigs
• Experimental bone marrow transplants
Section 7: Prescription Drug Coverage

Prescription Drug Benefits
Covered drugs may be dispensed in quantities of up to a 30-day supply or, for certain maintenance drugs, 100-unit doses, whichever is greater. You have coverage for:

- FDA-approved drugs
- Compound medications containing at least one federal legend drug ingredient
- Injectable insulin
- Needles and syringes dispensed with injectable drugs
- Preventive Drugs covered under the Patient Protection and Affordable Care Act

You can get more information on covered drugs on our website at bcbsm.com/importantinfo, click on “Drug list and pharmacy information”.
**Prescription Drugs**

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

| Deductible | $1,300 per individual  
|            | $2,600 per family  
| Retail - 30 day supply | $10 copay after deductible - Generic drugs  
|            | $40 copay after deductible - Brand name drugs  
|            | $0 copay after deductible - OTC drugs  
|            | (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)  
| Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member’s copay.  
| Mail Order - 90 day supply | $20 copay after deductible - Generic drugs  
|            | $80 copay after deductible - Brand name drugs  
| Specialty Drugs – 30 day supply | $10 copay after deductible - Generic drugs  
| Retail and Mail Order | $40 copay after deductible - Brand name drugs  
| Member are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.  
| Oral and Injectable Contraceptives | Covered - 100% for Generic drugs; Brand name drugs are subject to the applicable copay/coinsurance  
| Retail and Mail Order |  
| Additional Services |  
| Smoking Cessation Drugs | Covered  
| Weight Loss Drugs | Covered  
| Impotency Drugs | Covered  
| Infertility Drugs | Covered  
| Diabetic Supplies | Not Covered  

**Features of your prescription drug plan**

| Prior authorization/step therapy | A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy.  
| Mandatory maximum allowable cost drugs | If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.  

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM’s approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.  

BCBSM provides administrative claims services only. Your employer is financially responsible for claims.

**Retail Pharmacy Prescription Drugs**

Your prescription drug coverage helps to ensure that you and your family have coverage for high-quality prescription drugs with minimal out-of-pocket costs. Here are some ways to get the most out of your employer-provided prescription drug plan.
- Use generic drugs. They are made with the same active ingredients and produce the same effects in the body as their brand name equivalents. They are approved by the Food and Drug Administration as safe, effective treatment options and they save you money.

- Take advantage of over-the-counter medications whenever possible.

- Let your doctor know right away if you are having difficulty with your prescription.

- In Michigan, when you go to a **Preferred Rx network pharmacy**, your prescriptions and refills are covered at 100 percent of the approved amount less your deductible, copayment or coinsurance.

- Outside Michigan, when you go to an **Express Scripts network pharmacy**, your prescriptions and refills are covered at 100 percent of the approved amount less your copayment or coinsurance.

- If you go to an **out-of-network pharmacy** (in Michigan or outside of Michigan), you must pay the full cost of each prescription or refill. You, not the pharmacist, will need to send a claim to us to get reimbursed. If the out-of-network pharmacy sends the claim to us, it will be rejected. Ask your pharmacist for an itemized receipt and follow the instructions in the “Filing Claims” section of the claim form. You will be reimbursed for 80 percent of the approved amount less your copayment or coinsurance.

### Mail Order Prescription Drugs

If you are taking medication regularly, you can have it delivered right to your home. You can order drugs to treat asthma, diabetes or other chronic conditions from Express Scripts.

If it is appropriate for you, your doctor can prescribe a 90-day supply of your medication. Express Scripts mail order pharmacy features:

- 24-hour access to specialist pharmacists who can explain how specific drugs work and what to look out for
- Help from a pharmacist in managing side effects of your medication
- Fast and free standard delivery of your medication
- Easy refills online or by phone

### Getting started

It’s easy to get the information and forms you need to get started:

**Online**

- Visit [bcbsm.com](http://bcbsm.com), the Blue Cross Blue Shield of Michigan website.
- Register and log in to **Member Secured Services**.
- Under **Hospitals, Physicians, Medications**, click **Express Scripts Online Pharmacy**.
By phone

Call the Express Scripts Pharmacy at 1-800-633-2662.

Generic Equivalent Drugs
Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. Your pharmacist has a complete list of covered generic equivalent drugs included in your coverage. With the exception of insulin, if there is a generic equivalent to a brand name drug, your pharmacy will dispense the generic equivalent when appropriate.

If you or your physician requests a brand name drug when a generic equivalent is available, you must pay for the difference in cost between the brand name drug and the generic equivalent in addition to your copayment or coinsurance. If your doctor feels there are special circumstances that require you to take a brand medication instead of the generic equivalent, ask your doctor to call Express Scripts to initiate a review.

To initiate a review:

- Ask your doctor to contact Express Scripts at 800-753-2851
- The review process usually takes 3-5 days. Both you and your doctor are sent a letter notifying you of the approval or denial of coverage. If your brand medication is not approved, you will be responsible for the cost difference between the brand name drug and the generic drug, plus the appropriate coinsurance or copayment.

Specialty Drugs
Members can receive specialty drugs through the mail from Walgreens Specialty Pharmacy or get them at a retail specialty network pharmacy. They are not available through Express Scripts by Mail. For the most up-to-date list, please see the Specialty Drug Guide on bcbsm.com or call the Customer Service phone number on the back of your Blues ID card.

Specialty Drugs are used to Treat Complex Conditions
Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs treat complex and chronic conditions, including:

- Cancer
- Chronic kidney failure
- Multiple sclerosis
- Organ transplants
- Rheumatoid arthritis
There are Two Ways to Fill Specialty Drug Prescriptions
You can fill prescriptions for specialty drugs at a retail pharmacy, but not all pharmacies will dispense specialty drugs. Call your pharmacy in advance to verify that it can fill your prescription.

Blue Cross Blue Shield of Michigan also offer mail order service through Walgreens Specialty Pharmacy. Walgreens provides you with specialty pharmacy mail order services and support programs.

If you have questions about BCBSM’s specialty drug program, please call Walgreens Specialty Pharmacy at 1-866-515-1355 or visit the website at WalgreensHealth.com.

 Ordering Specialty Medication is Easy
You can order your specialty drugs through Walgreens Specialty Pharmacy, and they’ll arrive right at your home. Just have your doctor fax your specialty medication prescription to Walgreens Specialty Pharmacy at 1-866-515-1356.

If you choose to order your specialty medication through Walgreens Specialty mail order pharmacy, you can receive the following support services anywhere in the U.S.

- Personal attention from a patient-care coordinator who will do all of the following:
  - Discuss the best way for you to take your medicine
  - Explain possible side effects
  - Help you understand your condition
  - Call to remind you when you need a refill

- Ancillary supplies, if they’re appropriate to administer your medication, are free with each new order and then as needed if you request them. These include syringes, alcohol swabs and sharps containers.

- Dedicated customer service staff is available Monday through Saturday at 1-866-515-1355. Automated ordering and emergency clinical support are available 24 hours a day, seven days a week also.

If you have any questions, call the Customer Service phone number on the back of your Blues ID card.

Limited Distribution Specialty Drugs
Some manufacturers limit the distribution of specialty drugs. These drugs (noted on the specialty drug list) are only available through designated pharmacies. BCBSM has been able to secure access to these drugs through Accredo–Express Scripts' specialty pharmacy. Accredo can be contacted at 1-800-803-2523.
Pharmacy Cost-Saving Programs
The BCBS pharmacy initiatives are a series of cost-saving programs that provide additional ways to reduce drug costs. The following is a summary:

- **Prior Authorization / Step Therapy** for targeted drugs, clinical criteria must be met before coverage is approved.

- **Dose Optimization** encourages the use of select prescription drugs in once-daily dosage regimens at a lower cost rather than higher cost multiple daily doses.

- **Brand to Alternate Generic Interchange** encourages the interchange of brand name drugs with less costly generic alternatives.

- **Generic Copay Waiver** is offered when you switch to a generic equivalent of a multi-source brand. It targets brand name drugs that have a generic equivalent already on the market. When you agree to switch, you’ll receive a one-time free copay for the generic drug.

  **Note:** If your plan has a deductible and your deductible has not been met, there will be no copay to waive.

- **Quantity Limits** restrict the dispensing of targeted drugs in quantities inconsistent with FDA-approved labeling for the drugs. Medical necessity authorization is required to dispense quantities that exceed the limit.

- **Off-Label/High Cost Specialty Review** ensures you are using medication as recommended by the FDA guidelines.

Filing Claims
To file a drug claim, do the following:

1. Obtain an itemized receipt from the pharmacy that includes the following information:
   - Date the prescription was filled
   - Name and address of the pharmacy
   - NDC (National Drug Code) number
   - Name of drug and strength
   - Quantity and days’ supply
   - Prescription number (Rx number)
   - DAW (Dispense As Written) – if applicable
   - Amount Paid

2. Complete a Prescriptions Direct Reimbursement Claim form for each family member.

  **Note:** Use a separate claim form for each pharmacy from which you purchase prescriptions.
3. Attach up to two itemized receipts to each claim form.

4. Review the claim form to be sure it is accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign each claim. Always keep a copy of your claim forms and receipts.

5. Mail completed claim forms to the address in the front of this handbook, which is also shown on the claim form.

**Prescription Drug Exclusions and Limitations**

Exclusions and limitations that apply to your prescription drug coverage are listed below. These are in addition to applicable exclusions and limitations listed elsewhere in this handbook.

- Drugs that cost less than your copayment
- Administration of drugs or any drug consumed at the time and place of the prescription order
- Refills not authorized by a physician
- Therapeutic devices or appliances, even if prescribed by a physician (for example, support garments regardless of their intended use)
- More than a 30 day supply, except for specified maintenance drugs that are covered for 100-unit doses (retail pharmacy)
- Certain specialty drugs are limited to only a 15 day supply for each fill
- Refills dispensed after one year from the date of the original order
- Prescription drugs prescribed for cosmetic purposes
- Any vaccine given solely to resist infectious diseases
- Any drug determined by BCBS to be experimental or investigational, medical foods, homeopathic or herbal
- Any drug that does not require a prescription
- Drugs or services obtained before the effective date or after the contract ends
- Prescriptions issued by anyone who is not legally authorized to prescribe drugs for human use
- Drugs for which the cost is included in the charge for other services or supplies
- Diagnostic agents
- Any drug or device prescribed for indications (uses) other than those specifically approved by the Federal Food and Drug Administration.
- Drugs that are not labeled, "Caution: Federal law prohibits dispensing without a prescription," except for state-controlled drugs
- Covered drugs or services dispensed to a member when such services are benefits under other BCBS certificates
- Drugs or services covered by government sponsored health care programs, such as Medicare or TRICARE
- More than 12 doses of an impotence drug such as Viagra in a 30-day period;
- More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains prior authorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM website at bcbsm.com
- Non-self-administered injectable drugs
- Non-self-administered contraceptive drugs or devices
- Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device. (However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it was prescribed. See criteria under “Covered Drug” in “The Language of Health Care” section.) Some chemotherapeutic drugs may be subject to prior authorization review.
- Chemotherapy specialty pharmaceuticals that are not preauthorized
- Compounded drugs that contain any bulk chemical powders that are not approved by BCBSM
- Claims for covered drugs or services submitted after the applicable time limit for filing claims
Section 8: Medicare and Supplemental Coverage

This section describes the benefits available under your Medicare and Supplemental coverage. This coverage is available only to members who are 65 or older, to persons who have end stage renal disease (ESRD) and to certain disabled persons.

Medicare Coverage
Medicare is a federal health care program designed to provide health care benefits to persons aged 65 and older, to persons who have ESRD and to certain disabled persons. The Social Security Administration is the sole authority for determining your Medicare eligibility. If you are enrolled in this coverage, you are called a beneficiary.

You become eligible for Medicare when you are 65 (or earlier if you are disabled or have ESRD). If you are eligible by reason of age, you may enroll at any time during a seven-month period. This period begins three months before the month in which you reach 65, and includes the actual month of your birthday and the three months following your birthday month. During this period, you must apply for Medicare through your local Social Security Administration office.

Medicare coverage has two parts: hospital insurance (Part A) and medical insurance (Part B). Hospital insurance helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. Medical insurance helps pay for physician's services and other medical services and items.

The hospital insurance portion is provided at no cost to you. However, you must pay monthly for the medical insurance portion. This premium is adjusted annually. You will be notified of the change before each new year.

Employed Persons Aged 65 or Older
When you reach 65 and become eligible for Medicare, but are still working for an employer of 20 or more persons, you have two options for health care coverage. You may either:

- Continue your regular current coverage as your primary health care plan
- Select Medicare as your primary health care plan.
- The following explains these options:

Option 1
You may continue your regular current coverage as your primary health care plan. This is automatic unless you indicate in writing that you do not want to continue.

Important: If you continue to be covered by your group plan as your primary plan, you should still apply for Medicare benefits, especially Part A.
• Part A of Medicare, the hospital insurance, is offered without cost to you. It may provide additional benefits to your group coverage.

• Part B of Medicare, the medical insurance, also is available for a monthly premium. However, you can delay enrollment in Part B without penalty.

If you delay enrolling in Medicare Part B coverage when you reach 65, you may enroll during the special enrollment period that begins on the first day of the first month in which you are no longer covered by your group plan and ends seven months later.

Option 2
You may select Medicare as your primary health care plan. However, if you select this option, federal regulations prohibit your employer from providing you with Supplemental coverage.

Note: If you have a spouse who is 65 or older and is covered under your group plan, your employer must provide the same coverage you select to your spouse until you retire or leave employment.

Blue Cross Blue Shield Supplemental Coverage for Members on Medicare
If you have Supplemental coverage, it works with your Medicare coverage to extend your health care benefits. Supplemental coverage works like this:

• Medical Coverage—Your group coverage, in combination with Medicare, provides the same benefits described throughout this handbook. Your Medicare deductibles and coinsurance are covered if the service is a covered medical benefit. You are still responsible for any medical deductible and coinsurance/copayments required under the Supplemental coverage.

• Prescription Drug Coverage — Your benefits remain as described in the “Prescription Drug Coverage” section.

Supplemental Coverage Exclusions and Limitations
Your Blue Cross Blue Shield Supplemental coverage will not cover:

• Custodial nursing care (such as help with walking, getting in and out of bed, eating, dressing, bathing and taking medications) at home or in a nursing home

• Intermediate nursing care in a nursing home

• Private duty nursing or skilled nursing care not approved by Medicare

• Physician charges that are more than Medicare's allowed amount

• Injury or sickness covered by Workers Compensation

• Admissions or care provided by a government-owned or -operated hospital unless payment is required by law
• Admissions or care received **before** the effective date of coverage or **after** the coverage termination date

• Drugs other than prescription drugs furnished during your stay in a hospital or skilled nursing facility

• Dental care, dentures, routine physicals and immunizations, cosmetic surgery, routine foot care, and examinations for eyeglasses or hearing aids
Section 9: Filing Claims

When you use your benefits, a claim must be filed before payment can be made. If you go to participating providers, you will not have to file claims for medical services because claims are submitted directly to BCBS for you. However, if you receive medical services from non-participating providers, or you receive care out of the country, you may be required to file your own claims.

How to Submit a Claim

You should submit your claim as soon as you receive covered services. Generally, if you submit claims beyond the applicable filing limitation, they will be denied. The following filing limitation guidelines apply for most claims:

- The approved filing limits for pay-provider claims are 6 months from date of service for professional and 12 months from date of service for facility.
- The approved filing limits for pay-subscriber claims are 24 months from date of service.
- One year after the date of purchase for prescription drug claims, see the "Prescription Drug Coverage" section for filing instructions.

If you need a claim form, contact your employer or call a BCBS customer service representative.

To file a claim, follow these steps:

1. Obtain an itemized statement from the provider that includes the following information:
   - Name of the patient and the subscriber
   - Enrollee ID (from your ID card)
   - Provider’s name and address
   - Provider's federal tax ID number
   - Description of services
   - Diagnosis (nature of illness or injury)
   - Date of each service
   - Dates of admission and discharge (if admitted to a hospital)

   You may include cash register receipts, canceled checks or money order stubs with your itemized receipt, but they may not substitute for an itemized receipt.

   Note: If you receive medical services out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and U.S. currency amounts.
2. Complete a separate claim for each family member. Multiple services for the same patient may be attached to one claim.

3. Attach all itemized receipts and statements to the claim form. Make sure the subscriber's name and enrollee ID from the BCBS ID card are on all receipts and attachments.

4. Review all claims to be sure they are accurate and complete. **Incomplete forms will cause your payment to be delayed.** Be sure to sign and date each claim. Always keep a copy of your claims and receipts because BCBS cannot return them to you.

5. Mail all claims to the address shown on the form. If you do **not** have a claim form, send the itemized receipt to your BCBS customer service office. Addresses are listed on the inside front cover of this handbook.

**Explanation of Benefits (EOB)**
We will send you an explanation of benefits statement after we have processed your claim. The EOB shows you what services have been paid by BCBS and what, if anything, you owe. It is not a bill.

If your claim is denied, the EOB will explain why the service or part of the charge was not covered. Please check this form carefully to make sure that you received the services listed. It is very important that you notify us if you did not receive the services or if there are any discrepancies.

**Online EOB**
Online EOB statements provide the same information as paper EOB statements but allow you to view statements quickly and easily 24 hours a day, seven days a week. You can access your online EOB statements by visiting [bcbsm.com](http://bcbsm.com) (login or register online to access your account).

Online EOB statements allow you to view statements securely from any personal computer, search for statements by date or patient name, track benefit payments, and download or print statements.

**Note:** When you sign up to receive online EOB statements, you will no longer receive paper statements through the mail.

**What to do if a Claim is Denied**
If your medical claim was not paid, in whole or in part, your EOB will indicate the reason for nonpayment. You can get more information on how to file an appeal on our website at [bcbsm.com/importantinfo](http://bcbsm.com/importantinfo), under "Important Notices About How Your Coverage Works", click on “Appealing a claims decision”.
Section 10: Other Information

This section includes helpful information about these important topics:

- Coordination of benefits (COB)
- Subrogation
- No-fault auto coverage
- Access to our staff
- When you have a complaint
- How we review new technology

Coordination of Benefits

COB is how health care plans coordinate benefits when you are covered by more than one health care or motor vehicle insurance plan. Your company’s health care plan, which is administered by BCBS, requires that your benefit payments be coordinated with benefit payments from another health care or motor vehicle insurance plan for services that may be payable under either plan, so that payment responsibilities will be fair. If you are covered by more than one health care or motor vehicle insurance plan, COB guidelines (explained below) determine which plan pays for covered services first. COB letters of inquiry, which request information about other plans, may be sent on an annual basis in order to keep our records up to date.

The plan that pays first is your primary plan. This plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is your secondary plan. This plan provides payments toward the balance of the cost of covered services — up to the total allowed amount.

COB makes sure that the level of payment, when added to the benefits payable under another plan, will cover up to the total of the eligible expenses. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

Guidelines to Determine Which Plan is Primary and Secondary

- If a group health plan does not have a COB provision, then that group health plan is primary.
- If a group health plan does have a COB provision, the plan that covers the patient as the employee (subscriber) is primary and pays before a plan that covers the patient as a dependent.
- If a dependent child is covered under either parents’ (or legal guardians’) plans, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- For children of divorced or separated parents, benefits are determined in the following order unless a Qualified Medical Child Support Order or divorce decree places financial responsibility on one parent:
1. Plan of the custodial parent
2. Plan of the custodial parent's new spouse (if remarried)
3. Plan of noncustodial parent
4. Plan of noncustodial parent’s new spouse (if remarried)

**Note:** If custody is not known, then the birthday rule is used to determine the order of benefits for children of divorced, separated or never married parents.

When an employee is the subscriber on multiple group health insurance policies:

- If both contracts are either “active employee” or are “retired employee,” then the group health insurance in effect the longest is the primary plan, and the other contract is the secondary plan. (Note: Refers to coverage supplied by the employer group, not which health insurance carrier has supplied coverage longer)

- If one contract is “active employee” and one is “retiree/laid-off COBRA,” then the “active employee” group is the primary plan and the “retiree/laid-off COBRA” employer group is the secondary plan.

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

**Updating COB Information — Your Responsibility**

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your employer immediately. Please help us serve you better by responding to requests for COB information quickly. We will request updated COB information yearly. If COB information such as cancellation of other coverage, switching other coverage carriers or changes in custody or court ordered coverage for dependent children is not updated, claims could reject inappropriately or send incorrect messages to your health care providers.

If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under your contract for your spouse or dependent children, the claim will be temporarily held. We will send you a new letter of inquiry requesting information about other carriers. When you respond, we will update your record. Your claim will then be processed according to the appropriate COB rules.

**Important:** If you do not respond to our letter of inquiry within 45 days of its receipt, the claim will be denied due to lack of current COB information. In addition, all other claims for your spouse and dependents will be denied until the COB letter of inquiry is returned.
Specific Information about Your COB
Your plan includes non-duplicative COB payment. This means:

- When your BCBSM contract is the secondary (or tertiary) payer, you remain responsible for all primary patient liability resulting from primary insurance sanctions, penalties or network restrictions, unless your primary insurer is an HMO.

- As secondary (or tertiary) payer, we will not apply contract network restrictions unless the primary insurer denied benefits for the service.

- As secondary (or tertiary) payer, we will cover the remaining non-sanctioned patient liability up to the amount we would have paid had we been primary for BCBS covered services only.

Filing COB Claims to your Secondary Carrier
Always have your health care provider submit claims to your primary carrier first. Then have your provider submit a claim for the secondary balance to BCBS. If your provider will not submit a secondary claim to BCBS, then you can submit the claims as follows:

1. Obtain an explanation of benefits from the primary carrier.

2. Ask your provider for an itemized receipt or detailed description of the services, including charges for each service.

3. If you made any payments for the service, provide a copy of the receipt you received from the provider.

4. Make sure the provider's name and complete address are on your receipts. Also include the provider's tax ID number.

5. Send these items to the appropriate address as indicated on the claim.

Please make copies of all forms and receipts for your own files, because we cannot return the originals to you.

Subrogation
In certain cases, another person, insurance company or organization may be legally obligated to pay for health care services that BCBS has paid. When this happens:

- Your right to recover payment from them is transferred to BCBS.

- You are required to do whatever is necessary to help BCBS enforce its right of recovery.

- If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBS. However, this does not apply if the funds you receive are from additional coverage you purchased in your name from another insurance company.
No-Fault Auto Coverage
If you or your eligible dependents are involved in a motor vehicle accident, payment for medical services will be coordinated between BCBS and your auto insurance carrier as follows:

- Your no-fault auto insurance will be secondary to BCBS coverage.

It is important that you discuss this with your auto insurance company.

Access to our staff
Blue Cross Blue Shield of Michigan works with our network providers to improve delivery of health care and to improve outcomes. We want to make sure you’re getting the highest quality care and service, and that you receive it promptly. This is called utilization management. If you have questions or want more information about this process and the approval of care, please call the Customer Service number on the back of your ID card. TTY users: start by dialing 711.

When you have a complaint
Blue Cross Blue Shield of Michigan and your primary care physician are interested in your satisfaction with the services you receive as a member. If you have a problem or concern about your care, we encourage you to discuss this with your primary care physician first. Often your primary care physician can correct the problem to your satisfaction. You are always welcome to call our Customer Service Department with any questions or problems you may have.

At any point during the complaint process, you may submit any information or evidence concerning the complaint to assist Blue Cross Blue Shield in our investigation. You may file a complaint or appeal verbally or in writing. Complaints will not be accepted through email. There are no fees or costs associated with filing a complaint. All complaints can be submitted through the Customer Service Department line or via mail to the address listed below:

**Customer Service Line:** Use the phone number on the back of your Blue Cross Blue Shield of Michigan ID card

**Address:**
BCBSM Complaints – Mail Code 2004
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Fax: 877-348-2210

How We Review New Technology
The Medical Policy Administration of Blue Cross Blue Shield of Michigan (BCBSM) and the Care Management department of Blue Care Network of Michigan (BCN) are responsible for the evaluation of new technologies and the new applications of existing technologies, the development of medical policies related to these technologies, and the development of coverage recommendations. This process includes, but is not limited to the following areas for potential
new technologies: medical procedures and services, medical devices, surgical procedures, behavioral health procedures, and pharmaceuticals.
Section 11:
Glossary — Health Care Terms

**Accidental injury** — 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 and medication overdosing; and inhaling smoke, carbon monoxide or fumes, attempted suicide.

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

**Allogeneic (allogenic) transplant** — A procedure using another person’s bone marrow or peripheral blood stem cells or umbilical cord to transplant into the patient (including syngeneic transplants, when the donor is the identical twin of the patient).

**Ambulatory surgery facility** — 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. It is not an office of a physician or other private practice office.

**Approved amount** — The BCBS maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles, coinsurances, copayments are deducted from the approved amount.

**Approved amount for prescription drugs** — Lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) paid to the pharmacy, not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

**Approved facility** — A provider, such as a hospital, clinic or freestanding facility that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements, and must have been approved as a BCBS provider.

**Approved hospital** — A hospital 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 BCBS.

**Autologous transplant** — A procedure using the patient’s own bone marrow or peripheral blood stem cells for transplantation back into the patient.

**BCBS** — Blue Cross Blue Shield

**BCBSA** — Blue Cross and Blue Shield Association, an Association of independent Blue Cross 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.

**BCBSM** — Blue Cross Blue Shield of Michigan, a non-profit mutual insurance company.

**BCBSM Custom Drug List** – A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the Blue Cross Blue Shield of Michigan Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.

**Benefit** — Coverage for health care services available in accordance with the terms of your health care coverage.

**Brand name drugs** – Prescription drugs that are patent protected. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under a generic name.

**Clinical trial** — 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 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.

**Closed Drug List**— Drugs not on this list are not covered, making the member responsible for the full cost of any non-covered drug that is dispensed.

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

**COBRA** — Continuation coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

**Coinsurance** — The percentage of the approved amount you are required to pay for covered services.

**Colony stimulating growth factors** – Factors that stimulate the multiplication of very young blood cells.

**Copayment** - Copayment is a flat dollar amount you must pay for eligible services.
Covered services — Services, treatments or supplies identified as payable in your employer’s coverage documents. Covered services must be medically necessary to be payable, unless otherwise specified.

Custodial care — Care mainly for helping a person with activities of daily living or meeting personal needs. It includes walking, getting in and out of bed, bathing, dressing, eating, taking medicine, etc. This care may be given with or without:

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Care supervised by a physician

Deductible — A specified amount that you pay during each benefit period for services before your plan begins to pay.

Designated cancer center — 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 — A facility that BCBS determines to be qualified to perform a specific organ transplant.

Designated services — Services that BCBS determines only a non-contracted area hospital is equipped to provide.

Durable medical equipment — Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury. This equipment must be prescribed by a physician.

Emergency first aid — The initial exam and treatment of conditions resulting from accidental injury.

Emergency medical condition — is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)
**ESRD** — End stage renal disease, chronic irreversible kidney failure that requires a regular course of dialysis or a kidney transplant to maintain the patient’s life.

**Experimental or investigational** — A service, procedure, treatment, device or supply that has not been scientifically proven to be safe and effective for treatment of the patient's condition. BCBS 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 BCBSA or other local or national bodies

**Freestanding facility** — A facility separate from a hospital that provides outpatient services, such as substance abuse treatment, rehabilitation, skilled nursing care or physical therapy.

**Generic drugs (Tier 1)** — Non-brand name drugs that produce the same effects in the body as the equivalent brand name drugs. The Food and Drug Administration requires that generic drugs have the same active ingredients as the equivalent brand name drugs. They may differ from brand name drugs in color and shape. Since the major difference between brand name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate. They also require the lowest copayment, making them the most cost-effective option for the treatment.

**Hospital** — A facility that provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and is fully licensed and certified as a hospital, as required by all applicable laws and complies with all applicable national certification and accreditation standards.

**Medical emergency** — A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury. Emergency services treat medical emergencies.

**Medically necessary** — A service must be medically necessary in order to be payable by your health care coverage.

Medically necessary **hospital services** are those that are:

- For the treatment, diagnosis or symptoms of an injury, condition or disease
- Appropriate for the symptoms and consistent with the diagnosis
- Not mainly for the convenience of the member or health care provider
- Not generally regarded as experimental or investigative by BCBS

Medically necessary **physician services** are determined by physicians acting for their respective provider types and medical specialty, and are based on criteria and guidelines developed by
physicians and other professional providers. Medically necessary physician services are those that are:

- 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.

- Determined by a physician or professional review according to generally accepted standards and practices, in the absence of established criteria.

- Based on standards of practice established by physicians, for BCBS payment purposes.

**Medicare** — Pays health care costs for eligible persons age 65 or older. Also pays for people younger than 65 diagnosed with end stage renal disease or entitled to Social Security or Railroad Retirement benefits because of a disability for at least 24 months.

**Member** — Any person eligible for health care services under your plan on the date the services are rendered. This includes you as the subscriber and any of your eligible dependents listed in BCBSM membership records.

**Negotiated rate** — In most cases, a simple discount arrangement.

**Network pharmacies** — Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx (in Michigan) or Express Scripts Health Prescription Solutions Inc. (outside Michigan) networks. Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

**Non-Preferred Brand (Tier 3)** — Tier 3 contains brand name drugs not included in the Preferred Brand tier. Members pay the highest copayment for these drugs under a triple-tiered plan. Non-Preferred drugs are not covered under a Closed Drug List plan.

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

- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury, or following surgery

- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living

- Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).
Out-of-area hospital — A BCBSM network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-network pharmacies — Pharmacies that are not a member of the Preferred Rx (in Michigan) or Express Scripts Health Prescription Solutions Inc. (outside Michigan) networks. Out-of-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

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

PCP - Primary Care Physician specialties include: Clinic Multi-Specialty, Family Practice, General Practice, Gynecology, OB- Gynecology, Internal Medicine, Obstetrics (DO), Pediatrics and Nurse Practitioners, unless otherwise noted.

Per claim participation — A provider's acceptance of the BCBSM approved amount as payment in full for a specific claim or procedure.

Peripheral blood stem cell transplant — A procedure where blood stem cells are obtained by pheresis and infused into the patient’s circulation.

Physical therapy — Treatment that is 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.

Note: Physical therapy is not covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).

Physician — A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as “practitioners.”

Preapproval — A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services, they will not be covered.

Preferred Brand (Tier 2) — Tier 2 includes brand name drugs from the Custom Drug List. Preferred Brand options are also safe and effective, but require a higher copayment.

Professional provider —

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist
• Chiropractor
• Fully licensed psychologist
• Clinical licensed master’s social worker
• Licensed Professional Counselor (LPC)
• Oral surgeon
• Board certified behavior analyst
• Other providers as identified by BCBSM
• Professional providers may also be referred to as “practitioners.”

Provider — A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care or a pharmacy legally licensed to dispense drugs.

• Network providers – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with BCBS to provide services to members enrolled in a PPO health care plan. Network providers have agreed to accept our approved amount as payment in full for covered services.
• Out-of-network, participating providers — Providers who are not part of the BCBS PPO provider network. Out-of-network, but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not a part of the PPO network, you must pay higher out-of-pocket costs.
• Non-Participating providers — Providers who have not signed participation agreements with BCBS agreeing to accept the BCBS payment as payment in full. However, non-participating professional providers may agree to accept the BCBSM approved amount as payment in full on a per claim basis.

Qualified Medical Child Support Order — A court order or court-approved settlement agreement that provides for health benefits for a child of a group health plan member or enforces one of the mandatory provisions of state law regarding the provision of health insurance to minors in such cases. A QMCSO gives the child the same rights as an employee to receive benefits under a group health plan.

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

Routine service — Procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.
Skilled nursing facility — A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse. 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.

Speech Pathology Severity Guidelines for Developmental Conditions — Severity criteria for developmental conditions are met when any of the following clinical situations are documented in the patient’s medical record:

- The child’s condition is scored within the severe range on a standardized test of communicative dysfunction.
- The child’s condition is scored within the severe range on a subtest of a standardized test of communicative dysfunction.
- The child is functionally non-verbal at the age of 2.5 years or older.
- The child tests at more than one year behind norms for receptive language on a standardized test of communicative dysfunction.
- The child tests at more than one year behind norms for expressive language on a standardized test of communicative dysfunction.
- The child tests at more than one year behind norms for articulation proficiency on a standardized test of communicative dysfunction.

The medical chart must demonstrate specific treatment goals based on the original and ongoing assessment of the child’s speech and language disorder. Measurement of progress toward those goals must be documented.

If a child’s severity status changes, as a consequence of treatment, while therapy is in progress, coverage will continue for the remainder of the treatments, depending on the contract limitations.

Speech and language pathology therapy — Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

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

Subscriber — The employee or COBRA qualified beneficiary who signed the enrollment form for BCBS coverage.

Substance abuse — Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause the person to lose self-control
- Endanger the safety or welfare of others because of the substance's habitual influence on the person
**Syngeneic transplant** – A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient’s identical twin to transplant into the patient.

**TRICARE** — A Department of Defense health care program for members of the uniformed services and their families. This includes members of the reserves and National Guard who are called to active duty and their families.

**We, us, our** – Used when referring to BCBS.

**You and your** – Used when referring to any person covered under the subscriber’s contract.
These codes relate to your health care plan and are for internal use by BCBS.

<table>
<thead>
<tr>
<th>Group Name:</th>
<th>Western Michigan Health Insurance Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding:</td>
<td>Self Funded</td>
</tr>
<tr>
<td>Effective date of coverage:</td>
<td>01-01-2016</td>
</tr>
<tr>
<td>Developer:</td>
<td>KM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Package Code</th>
<th>Section Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>71565</td>
<td>036, 037</td>
<td>3000, 3100, 3300, 3400</td>
</tr>
</tbody>
</table>