THIS IS A HEALTH BENEFIT PLAN

FOR

OAKLAND COUNTY

Community Blue PPO PLAN

Effective Date of January 1, 2019

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INTRODUCTION

OAKLAND COUNTY has established the Community Blue PPO Health Benefit Plan for Oakland County as a self-funded employer group health plan in order to provide certain benefit for certain Employees, Retirees, and their eligible Dependents. Oakland County executes this document, including any future addenda, to establish this Plan for the exclusive benefit of the participating Employees, Retirees, and their Dependents. This document is also considered to be the Summary Plan Description and is intended to explain the Plan. Please read this document carefully and acquaint your Family with its provisions.

This Plan, and any Employer-offered plans that are provided as an alternative to coverage under this Plan, shall together constitute a single plan for purposes of the nondiscrimination requirements of Section 105(h)(2) of the Code.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. Insurance may be purchased to protect the Employer against large claims. However, if for some reason the medical expenses that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

Plan Administrator

The Plan Administrator is **OAKLAND COUNTY**. The Plan Administrator shall have the authority and discretion to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator retains all rights to administer the Plan, regardless of the Claim Administrator's delegated responsibilities as specified throughout this Plan document.

Claim Administrator

The Claim Administrator of the Plan is Blue Cross Blue Shield of Michigan (BCBSM). The Claim Administrator shall only have the responsibilities delegated to it in writing in an Administration Agreement or other written agreement.

The Claim Administrator processes claims and does not insure that any medical expenses of Covered Persons will be paid.

OTHER BASIC INFORMATION ABOUT THE PLAN

1.	*Plan Name:*	Community Blue PPO Benefit Plan for Oakland County
2.	*Employer/Plan Sponsor Plan Administrator*	Oakland County 2100 Pontiac Lake Road Building 41 West Human Resources Waterford, Michigan 48328-0440 (248) 858-5212 (or for Retirees: [248] 858-8215)
3.	*Employer Identification No.*	38-6004876
4.	*Group Number*	007003532-0029, 0031, 0033, 0035, 0037
5.	*Type of Plan*	Welfare Benefit Plan providing medical benefits
6.	*Claim Administrator:*	Blue Cross Blue Shield of Michigan (BCBSM)
7.	*Type of Administration*	The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator.
8.	*Agent for Service of Legal Process:*	Manager of Human Resources Benefits Administration Division Oakland County 2100 Pontiac Lake Road Building 41 West Waterford, Michigan 48328-0440 For participating Employees, service of process may be made upon the Plan Administrator. For Retirees, service of process may be made upon the Retirement Administrator.
9.	*Effective Date of Amended and Restated Plan:*	January 1, 2019
10.	*Plan Year:*	January 1 through December 31

***PLEASE NOTE*: THIS PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION DESCRIBES THE CIRCUMSTANCES WHEN THE PLAN PAYS FOR HEALTH CARE. THERE MAY BE CIRCUMSTANCES WHEN YOU AND YOUR PHYSICIAN DETERMINE THAT HEALTH CARE THAT IS NOT COVERED BY THIS PLAN IS APPROPRIATE. REMEMBER THAT ALL DECISIONS REGARDING YOUR HEALTH CARE ARE UP TO YOU AND YOUR PHYSICIAN.**

NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA, does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, or beneficiaries have any rights under ERISA. The preceding statement also pertains to other federal laws that do not apply to the Plan.

HOW TO FILE A MEDICAL CLAIM

If the bill is not being submitted directly by the provider, please submit itemized copies of any bills that have been incurred to the Claim Administrator, at the following address:

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

If the claim is for an Injury, additional information will be required in order to proceed with processing. You must provide information in writing, detailing how, when, and where the Injury was received. Failure to provide this information may delay the timely processing of the claim.

CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

The Plan Administrator or Claim Administrator will try to review all information quickly. The Plan Administrator or BCBSM may request missing or additional data if needed. The Plan Administrator or BCBSM reserves the right to require an original claim form, billing statement or other necessary or appropriate documentation.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the diagnosis, the type of care or supply received, and the cost per item.

Generally, the provider of service (Hospital, Physician, laboratory, etc.) will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, BCBSM will, acting on behalf of the Plan Administrator, issue a check for the amount due and/or an "Explanation of Benefits." The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to BCBSM as soon as each bill is received, even if the Deductible (if applicable) has not yet been met. Please read this booklet before a claim occurs because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the Employer or BCBSM.

DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

Accidental Injury

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

a. Strains, sprains, cuts and bruises;
b. Allergic reactions caused by an outside force such as bee stings or another insect bite;
c. Extreme frostbite, sunburn, sunstroke;
d. Poisoning;
e. Drug overdosing;
f. Inhaling smoke, carbon monoxide or fumes;
g. Attempted suicide; and
h. A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Accredited Hospital

A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities. (Also see the definition of "Hospital" in this section.)

Active Employment

The Participant is an Employee who is eligible for Plan benefits and not terminated from employment with Oakland County.

Acute Care

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

Acute Care Facility

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

a. Custodial, convalescent, tuberculosis or rest care;
b. Care of the aged or substance abusers; and
c. Skilled nursing or other nursing care.

Administrative Costs

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

Administrative Functions

Activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out- benefits, such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative functions specifically do not include any employment-related functions.

Adverse Benefit Decision

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

Affiliate Cancer Center

A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

Allogeneic (Allogenic) Transplant

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

Ambulatory Infusion Center

A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

Ambulatory Surgery

Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a physician's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility

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

Ancillary Services

Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.

Annual Open Enrollment Period

The period during the year for making elections under the Plan. The beginning and ending dates of each Annual Open Enrollment Period shall be determined by the Employer and communicated to Participants.

Approved Amount

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

Approved Clinical Trial

Approved Clinical Trial means a Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

a. A federally-funded trial, as described in the Patient Protection and Affordable Care Act;
b. A trial conducted under an investigational new drug application reviewed by the Federal Drug Administration;
c. A drug trial that is exempt from having an investigational new drug application; and
d. A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Act

Arthrocentesis

Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Attending Physician

The physician in charge of a case who exercises overall responsibility for the patient's care:

a. Within a facility (such as a hospital and other inpatient facility);
b. As part of a treatment program; and
c. In a clinic or private office setting.

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

Audiologist

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

Autism Diagnostic Observation Schedule

The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the Michigan Department of Insurance and Financial Services, if this department determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Evaluation Center

An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

a. Evaluate and diagnose the member as having one of the covered autism spectrum disorders and
b. Recommend an initial high-level treatment plan for members with autism spectrum disorders.

Autism Spectrum Disorders

Autism spectrum disorders include Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

Autologous Transplant

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

BCBSM

Blue Cross Blue Shield of Michigan.

Behavioral Health Treatment

Evidence-based counseling and treatment programs, including applied behavior analysis, which meet both of the following requirements:

a. Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
b. Are 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.

Benefit Period

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

Biological

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

Birth Year

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

BlueCard PPO® Program

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

Blue Cross Blue Shield Global Core Program

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

Blue Cross Plan

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

Blue Distinction Total Care (BDTC)

A program that allows you to receive care management services outside the state of Michigan from a trained clinical care provider in a team effort with, and directed by, your primary care physician.

Blue Shield Plan

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

Board Certified Behavioral Analyst

An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered. 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.

Business Associate

A person or entity who does the following:

a. Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

b. Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

Calendar Year

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

Cancellation

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

Carrier

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

Case Management

A program that is designed to help manage the health care of members with acute or chronic conditions. It is up to BCBSM to decide whether you qualify for this program.

In certain circumstances, BCBSM may find it necessary to pay for services that are generally not covered by your contract but that are medically necessary to treat your condition. When this occurs, a case management contract must be signed by you (or your representative), your provider and the BCBSM case manager. This contract will define the services that will be covered under the case management program.

If BCBSM has contracted with a vendor to manage the case management program, then that vendor will make decisions regarding case management and sign any necessary case management documents on behalf of BCBSM.

Certified Nurse Midwife

A nurse who provides some maternity, contraceptive, and other services and who:

a. Is licensed as a registered nurse by the state of Michigan;
b. Has a specialty certification as a nurse midwife by the Michigan Board of Nursing; and
c. Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing.

Certified Nurse Practitioner

A nurse who provides some medical and/or psychiatric services and who:

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

Certified Registered Nurse Anesthetist

A nurse who provides anesthesiology services and who:

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

Change in Status

As set forth by HIPAA means any of the following:

a. An event that changes the Employee's legal marital status, including marriage, death of the Employee's spouse, divorce, legal separation (if recognized by the state in which the individuals reside), and annulment.
b. An event that changes the number of an Employee's dependents, including birth, adoption, placement for adoption, and death of a dependent.

c. An event affecting the employment status of the Employee, the Employee's spouse, or the Employee's dependent; including termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

d. An event that causes an Employee's dependent to satisfy or cease to satisfy the requirement(s) for coverage owing to the attainment of a specified age, student status, or any similar circumstance.

e. A change in the place of residence of the Employee, the Employee's spouse, or the Employee's dependent.

Chronic Condition

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

Claim Administrator

The person or firm, if any, retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. If there is no Claim Administrator (for any reason, including circumstances caused by the termination or expiration of the Administration Agreement with the initial Claim Administrator), or if the term is used in connection with a duty not expressly assumed by the Claim Administrator in a signed writing, the term shall mean the Plan Administrator. In no event will the use of the term Claim Administrator throughout this Plan document confer responsibilities that have not explicitly been delegated to the Claim Administrator in writing in an Administration Agreement or other written agreement between the Claim Administrator and the Plan Administrator.

Claim for Damages

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

Clinical Licensed Master's Social Worker

A clinical licensed master's social worker who provides some mental health services and who:

a. Is licensed as a clinical social worker by the state of Michigan.

b. Meets BCBSM qualification standards.

c. When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

Clinical Trial

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

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

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

A Federal law that may allow you to temporarily keep your health coverage after:

a. Your employment ends,
b. You lose coverage as a dependent of the covered employee, or
c. You have another qualifying event.
d. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay for you plus a small administrative fee.

Code

The Internal Revenue Service Code of 1986, as amended.

Coinsurance

The portion of the approved amount that you must pay for a covered drug or service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by an audit, adjustment, or recovery. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Colonoscopy

A colonoscopy is a procedure for viewing the interior lining of the large intestine (colon) using a small camera called a colonoscope.

Colony Stimulating Growth Factors

Factors that stimulate the multiplication of very young blood cells.

Congenital Condition

A condition that exists at birth.

Continuity of Care

Seamless, continuous care rendered by a specific provider that if interrupted, could have negative impacts on the specific condition or disorder for which the patient is being treated. Continuity of care also includes ongoing coordination of care in high risk patients that have multiple medical conditions.

Contraceptive Counseling

A preventive service that helps you choose a contraceptive method.

Contraceptive Device

A device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

Contraceptive Medication

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

Contract

The BCBSM certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Contracted Area Hospital

A BCBSM participating or in-network hospital located in the same area as a noncontracted area hospital.

Conventional Treatment

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

Coordination Period

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

Copayment

The dollar amount that you must pay for a covered drug or service. Your copayment is not altered by an audit, adjustment, or recovery. For prescription drugs, your copayment is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Cost Share

Copayments, coinsurances, and deductibles you must pay under this Plan

Covered Person

Any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

Covered Services

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

Custodial Care

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

Deductible

The amount that you must pay for covered services, under this Plan, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery. For prescription drugs, your deductible is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Dental Care

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

Dependent

a. The Participant's legal spouse who has met all of the requirements of a valid marriage contract in the state of marriage of the parties. A Participant's domestic partner (whether of the same or opposite gender) is not considered to be the Participant's legal spouse for Plan eligibility purposes.

b. A child who meets all of the following conditions:

   1. May be identified in one of the following categories:

      A. The Participant's natural child, the Participant's stepchild, the Participant's legally adopted child, or a child who is being placed for adoption with the Participant.

      B. A child who is under the legal guardianship of the Participant, is unmarried, and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of current legal guardianship status must be furnished to the satisfaction of the Plan Administrator.

      C. A child to whom the Participant is obligated to provide medical care coverage under an order or judgment of a court of competent jurisdiction and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

   2. Is less than 26 years of age. Coverage will continue through the end of the Calendar Year in which the child's 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 19 who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Claim Administrator prior to the end of the Calendar Year in which the child's 26th birthday occurs and upon request (i.e., the Plan Administrator may request additional proof from time to time).

c. A child for whom the Participant is obligated to provide medical coverage under a National Medical Support Notice, notwithstanding the above.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant may be asked to reimburse the Plan if it is discovered that he/she has provided false information.

In the event of a Retiree's death, any surviving Dependents of the Retiree may also be eligible to be covered under the Plan as specified in the Retiree Coverage section. Such surviving Dependents will be subject to the terms of this definition, except when the terms are deemed by the Claim Administrator to no longer be applicable as a result of the Participant's death.

For purposes of providing coverage to a Dependent pursuant to an Employee or Retiree electing to enroll in the Employer's Medicare Supplemental coverage, the term "Participant," as used in this

definition, means the Employee or Retiree who is eligible for and enrolled in the Medicare Supplemental coverage offered by the Employer but who is not enrolled in this Plan.

Dependent excludes these situations:

a. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.

b. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

Department of Insurance and Financial Services (DIFS)

The department that regulates insurers in the state of Michigan.

Dependent Coverage

Coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent or, if allowable under the Plan, for Routine preventive care for a Dependent.

Designated Cancer Center

A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Designated Facility

To be a covered benefit, human organ transplants must take place in a "BCBSM-designated" facility. A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant. The Plan has a list of designated facilities and will make it available to you and your physician upon request.

Designated Services

Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

Detoxification

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

Developmental Condition

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

Diagnostic Agents

Substances used to diagnose rather than treat a condition or disease.

Dialysis

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

Direct Supervision

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

Diversional Therapy

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

Dual Entitlement

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

Durable Medical Equipment

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

Effective Date

The date your coverage begins under this contract.

Eligibility

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

Emergency Care

Care to treat an accidental injury or medical emergency.

Emergency Medical Condition

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:

a. 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
b. Serious impairment to bodily functions, or
c. 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).

Emergency Services

Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

Employee

A common-law employee of the Employer. An independent contractor is not an Employee. Further, a leased employee within the meaning of Code Section 414(n) is not an Employee. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common-law employee of the Employer.

Employment Retirement Security Act of 1974

A federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

Employer

The Employer is **OAKLAND COUNTY**.

End Stage Renal Disease (ESRD)

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

Enrollment Date

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

Entitlement (or Entitled)

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

ERISA

The Employee Retirement Income Security Act of 1974, as amended, Section 3(1), 29 U.S.C. §1002(1). See Employee Retirement Income Security Act of 1974.

Essential Health Benefit

The term “Essential Health Benefit” has the meaning set forth by Health Care Reform. A list of Essential Health Benefits can be viewed by logging on to the Claim Administrator’s Website address printed on the back of the Covered Person’s identification card.

Evaluation

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

Exclusions

Situations, conditions, or services that are not covered by the Plan.

Exigent Circumstance

An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on the Plans approved drug list.

Experimental Treatment

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

Facility

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

Family

A Participant and any Dependent(s).

Family and Medical Leave Act of 1993

A federal law that provides certain employees with unpaid, job-protected leave each year, the duration of which is pre-determined by the federal government. It also requires that their group health benefits be maintained during the leave. See FMLA.

Fecal Occult Blood Screening

A laboratory test to detect blood in feces or stool.

Federal Food and Drug Administration (FDA)

An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

First Degree Relative

An immediate family member who is directly related to the patient: a parent, sibling or child.

First Priority Security Interest

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

a. Judgment or settlement of a legal action;
b. Settlement not due to legal action;
c. Undisputed payment; and
d. This right may be invoked without regard for:

    1. Whether plaintiff's recovery is partial or complete;
    2. Who holds the recovery; and

3. Where the recovery is held.

Flexible Sigmoidoscopy

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

FMLA

The Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat. 6 (29 U.S.C. 2601 et seq.). See Family and Medical Leave Act of 1993.

Freestanding Outpatient Physical Therapy Facility

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

Full-Time Employment

A basis by which a Participant is employed and is compensated for services by the Employer for at least the number of hours per week stated in the eligibility requirements of the Schedule for Eligibility and Participation. The work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel. A full-time Employee who is absent from work because of a health condition is considered to work in Full-Time Employment for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation. Additionally, a full-time Employee who is absent from work because the Employer has granted a Leave of Absence without Pay (as this leave is further defined in the Employer's policies) is generally considered to work in Full-Time Employment for the first ten days of one Employer-sanctioned leave per Calendar Year for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

Gender Dysphoria

A broad diagnosis that covers a person's emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gender Reassignment Services

A collection of services that are used to treat gender dysphoria. These services may include hormone treatment and/or gender reassignment surgery, as well as counseling and psychiatric services. These services must be medically necessary to be payable by BCBSM. BCBSM will not pay for services that it considers to be cosmetic. BCBSM will also not pay for services that are experimental or investigational.

Group

A collection of members under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination

A history and physical examination of the female genital tract.

Hazardous Medical Condition

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

Health Care Reform

The collective body of legislation that originated with the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) and grew to include any later laws that amend either of those Acts directly or indirectly, in whole or in part.

Health Insurance Portability and Accountability Act of 1996

The term "Health Insurance Portability and Accountability Act of 1996" means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

Health Maintenance Examination

A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant

A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

Hemodialysis

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

High-Dose Chemotherapy

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

High-Risk Patient

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended (Public Law 104-191). See Health Insurance Portability and Accountability Act of 1996.

HLA Genetic Markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests

using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency

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

Hospice

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

Hospital

A facility that:

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

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

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

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

Hospital Privileges

Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

Host Blue

See definition of "Host Plan."

Host Plan

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

Independent Occupational Therapist

An occupational therapist who provides some occupational therapy services and who:

a. Is licensed as an occupational therapist by the state of Michigan;
b. Meets BCBSM qualification standards; and

c. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Physical Therapist

A physical therapist who provides some physical therapy services and who:

a. Is licensed as a physical therapist by the state of Michigan;
b. Meets BCBSM qualification standards; and
c. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Speech-Language Pathologist

A speech-language pathologist who provides some speech-language therapy services and who:

a. Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses;
b. Meets BCBSM qualification standards; and
c. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy

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

Injectable Drugs

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

Injury

See: Accidental Injury

In-Network Providers

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

Irreversible Treatment

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

a. The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
b. The treatment is intended to cause permanent change to a person's bite or position of the jaws.
c. The treatment includes, but is not limited to:

    1. Crowns, inlays, caps, restorations and grinding;
    2. Orthodontics, such as braces, orthopedic repositioning and traction;

3. Installation of removable or fixed appliances such as dentures, partial dentures or bridges; and
4. Surgery directly to the jaw joint and related anesthesia services
5. Arthrocentesis

Jaw Joint Disorders

These include, but are not limited to:

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

Licensed Professional Counselor (LPC)

A licensed professional counselor who provides some mental health services and who:

a. Is licensed as a professional counselor by the state of Michigan;
b. Meets BCBSM qualification standards;
c. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM and/or the Plan paid as a result of the plaintiff's injuries.

Life-threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease of condition is interrupted.

Line Therapy

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Lobar Lung

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

Long-Term Acute Care Hospital

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

Mammogram

An imaging study of the breast using X-rays. It may consist of two or more x-ray views of each breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography. There are two types of mammograms:

a. Screening mammograms assess patients without any signs or symptoms to assist in the early identification of breast disease
b. Diagnostic mammograms assess patients in whom signs and symptoms of breast disease are present

Mandibular Orthotic Reposition Device

An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care

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

Maxillofacial Prosthesis

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

Maximum Payment Level

The most BCBSM will pay for a covered service. For participating or in-network providers, it is the amount BCBSM pays the provider under the provider's contract with BCBSM. For services provided by nonparticipating or out-of-network providers, it is the amount BCBSM pays for the service to its participating or in-network providers or the amount BCBSM negotiates with the nonparticipating or out-of-network provider. Maximum payment level is not a "Medicare-like rate" described in 42 C.F.R. §136.30, et. seq.

Medical Emergency

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

Medical Evidence Report

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

Medically Necessary

A service must be medically necessary to be covered. There are two definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons) and other providers; another applies to hospitals and LTACHs;

a. Medical necessity for payment of professional provider and other provider services:

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

   1. In accordance with generally accepted standards of medical practice;

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

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

c. Medical necessity for payment of hospital and LTACH services:

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

1. The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
2. The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
   Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

   A. For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
   B. The service is not mainly for the convenience of the member or health care provider.
   C. The treatment is not generally regarded as experimental by BCBSM.

   The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

Medicare

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

Member

Any person eligible for health care services under this Plan on the date the services are rendered. This means the employee and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services

Network Providers

Also called "in-network providers".

Newborn Care

Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the mother's attending physician and routine care during the newborn's inpatient stay.

Noncontracted Area Hospital

A BCBSM nonparticipating and out-of-network hospital located in an area defined by BCBSM.

Nonparticipating Hospital

A hospital that has not signed a participation agreement with BCBSM to accept the Plans approved amount as payment in full.

Nonparticipating Providers

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

OBRA 1993

The Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 (August 10, 1993). See Omnibus Budget Reconciliation Act of 1993.

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:

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

Off-Label

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

Omnibus Budget Reconciliation Act of 1993 (OBRA 1993)

A federal law that adds a provision to COBRA's tax code rules regarding pediatric vaccine coverage.

Online Visit

A structured online health consultation using secure audio-visual technology to connect a professional provider in one location to a member in another location for the purpose of diagnosing and providing medical or other health treatment.

Orthopedic Shoes

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

Orthotic Device

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

Out-of-Area Hospital

A BCBSM in-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-Area Services

Services available to members living or traveling outside a health plan's service area.

Out-of-network Providers

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

Outpatient Mental Health Facility

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

Outpatient Substance Abuse Treatment Program

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

Pap Smear

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

Partial Hospitalization Program (PHP)

Treatment for mental or emotional disorders provided by a hospital or OPC to a patient who lives at home and goes to a hospital or OPC.

Partial Liver

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

Participant

A person who is or was directly employed and compensated for services by the Employer, who meets the other eligibility requirements, and who is properly enrolled in the Plan. The term includes a Retiree who meets the other eligibility requirements and who is properly enrolled in the Plan, if the Plan’s eligibility requirements permit Retiree participation.

Participant Coverage

Coverage included under this Plan providing benefits payable as a consequence of an Injury or Illness of a Participant or, if allowable under the Plan, for Routine preventive care for a Participant.

Participating Hospital

A hospital that has signed a participation agreement with BCBSM to accept the plans approved amount as payment in full. Your cost share, which may be required of you, are subtracted from the approved amount before the Plan makes a payment.

Participating PPO Provider

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

Participating Providers

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

Part-Time Eligible Position

A basis by which a Participant is employed in a position that is considered by the Employer to be eligible for Plan coverage and is compensated for services by the Employer for at least the number of hours per Calendar Year specified in the Employer's policies. The work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel. An Employee who is absent from work because of a health condition is considered to be working in a Part-Time Eligible Position for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

Patient

The member or eligible dependent that is awaiting or receiving medical care, treatment or covered drugs.

Pay-Provider Claim

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

Pay-Subscriber Claim

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

Per Claim Participation

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

Period of Crisis

A period during which a patient requires continuous care (primarily nursing care) to alleviate or manage acute medical symptoms.

Peripheral Blood Stem Cell Transplant

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

Peritoneal Dialysis

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

Pheresis

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

PHI

See Protected Health Information.

Physical Therapist

A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

Physical Therapy

The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to keep, learn, retain or improve:

a. Muscle strength
b. Joint motion
c. Coordination
d. General mobility

Physician

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

Physician Assistant

A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

Plaintiff

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

Plan

The BCBSM PPO2 Self-Funded Health Benefit Plan for Oakland County, as periodically amended by the County.

Plan Administrator

The Plan Administrator is **OAKLAND COUNTY** who is responsible for the day- to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Plan Sponsor

The Plan Sponsor is **OAKLAND COUNTY**.

Plan Year

The 12-month period that begins on January 1 and ends on the following December 31. This time period is used for purposes of determining annual benefit- based accumulators (e.g., Deductibles and out-of-pocket limits), Form 5500 reporting (if required), compliance with the Patient Protection and Affordable Care Act (PPACA), as amended, and compliance with other laws impacting the Plan.

Post-service Grievance

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

Practitioner

A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master's social worker or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as "participating" or "in-network" provider.

Pre-service Grievance

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

Preapproval

A process that allows you or your provider to know if the Plan will cover proposed services before you receive them. If preapproval is not obtained before you receive certain services described in this document, they will not be covered.

Preapproval Process

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

Preferred Provider Organization (PPO)

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

Prescription

An order for medication or supplies written by a health care professional authorized by law to prescribe "Rx only" drugs for the treatment of human conditions.

Presurgical Consultation

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

Primary Care Physician (PCP)

The physician you choose to provide or coordinate all of your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

a. Family Practice
b. General Practice
c. Internal Medicine
d. Pediatrics

Primary Payer

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

Primary Plan

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

Prior Authorization Process related to Autism Services

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavior analysis services. A request for continued services will be authorized contingent on the member meeting a mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at three, six, or nine month intervals or at other mutually agreed upon intervals after the onset of treatment.

Professional Provider

One of the following:

a. Doctor of Medicine (M.D.);
b. Doctor of Osteopathy (D.O.);
c. Podiatrist;
d. Chiropractor;
e. Physician Assistant (PA);
f. Fully licensed psychologist;
g. Limited licensed psychologist (LLP)
h. Clinical licensed master's social worker (CLMSW);
i. Licensed marriage and family therapist (LMFT);
j. Licensed professional counselor (LPC);
k. Oral surgeon;

l. Independent physical therapist (IPT);
m. Independent speech therapist (IST);
n. Independent occupational therapist (IOT);
o. Certified nurse practitioner (CNP);
p. Certified nurse midwife (CNM);
q. Certified registered nurse anesthetist (CRNA);
r. Board certified behavior analyst; and
s. Other providers as identified by BCBSM.

Professional providers may also be referred to as "practitioners."

Prosthetic Device

An artificial appliance that:

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

Protocol

A detailed plan of a medical experiment or treatment.

Protected Health Information

Information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care to a Covered Person, or the past, present, or future payment for the provision of health care to a Covered Person. Also, the information identifies the Covered Person or there is a reasonable basis to believe the information can be used to identify the Covered Person (whether living or deceased). The identifiers listed in 45 CFR 164.514(b)(2)(i) will enable identification.

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.

Provider-Delivered Care Management (PDCM)

A program that allows you to receive care management services in Michigan from a trained clinical care manager in a team effort with, and directed by, your primary care physician.

Psychiatric Residential Treatment Facility

A facility that provides residents with 24-hour mental health care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

Psychologist

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

Purging

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

Qualified Beneficiary

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

Qualified Individual

An individual eligible for coverage under this Plan who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

a. The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
b. The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Qualifying Event

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

a. Termination of employment, other than for gross misconduct, or reduction of hours;
b. Start of Military Service. Members must perform military duty for more than 30 days
c. Death of the employee;
d. Divorce;
e. Loss of dependent status due to age; and
f. The employee becomes entitled to coverage under Medicare.

The examples in this definition are not exhaustive and may change. Please call BCBSM Customer Service for more information about qualifying events.

Radiology Services

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

Refractory Patient

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

Registered Provider

A participating or nonparticipating provider (or in-network or out-of-network PPO provider) that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Relapse

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

Remitting Agent

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

a. Collect or deduct premiums from wages or other sums owed to the member and
b. Pay the member's BCBSM bill

Rescission

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

Research Management

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

Residential Substance Abuse Treatment Program

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

Respite Care

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

Retail Health Center

A medical center located inside a retail store. It offers “walk-in” care for minor conditions, provided by a professional provider.

Retired Employee; Retiree

A person is or was eligible for benefits under this Plan as a Retiree as defined by the Employer. For details on Retiree coverage and the rules for such coverage, including, but not limited to, the specific hire dates applicable to each bargaining unit, refer to the Employer’s written policies.

Reversible Treatment

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

a. The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
b. This treatment is not intended to cause permanent change to a person's bite or position of the jaws.
c. This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:

    1. Arthrocentesis.
    2. Physical therapy.
    3. Reversible appliance therapy (mandibular orthotic repositioning).

Rider

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

Right of Recovery

The right of the Plan to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by the Plan.

Routine Patient Costs

Routine Patient Costs means all items and services related to an approved clinical trial if they are covered under this Plan for members who are not participants in an approved clinical trial. They do not include:

a. The investigational item, device, or service itself;
b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber

Any provider who has been disciplined under Section 1128 and Section 1902(a) (39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

Screening Services

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

Secondary Plan

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

Self-Dialysis Training

Teaching a member to conduct dialysis on him or herself.

Semiprivate Room

A hospital room with two beds.

Service Area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks. BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services

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

Skilled Care

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

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

Skilled Nursing Facility

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

Small Bowel Transplant

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

Special Enrollment Period

The period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are described in the Participant Enrollment and Dependent Enrollment sections and are in general prescribed by HIPAA and federal regulations issued pursuant to HIPAA.

Special Medical Foods

Special foods that are formulated for the dietary treatment of inborn errors of metabolism. The nutritional requirements of the patient are established by a physician's medical evaluation of the patient. The diet must be administered under the supervision of a physician.

Specialist

A provider with a specific skill or expertise in the treatment of a particular condition or disease.

Specialty Hospitals

Hospitals that treat specific diseases, such as mental illness.

Specialty Pharmaceuticals

Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. Select specialty pharmaceuticals require preauthorization from BCBSM.
Examples of specialty pharmaceuticals include, but are not limited to, the following:

a. Drugs administered by infusion therapy providers
b. Drugs administered in the office by health care practitioners
c. Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency

d. Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

The Plan will cover these drugs under the section of the Plan that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the section that applies to your medical benefits.

Specialty Pharmacy

Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Spouse

An individual who is legally married to the member and meets the Plan's eligibility requirements.

Stabilize

Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

Stem Cells

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

Subrogation

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

Subscriber

The person who signed and submitted the application for coverage.

Substance Use Disorder

Taking alcohol or other drugs in amounts that can:

a. Harm a person's physical, mental, social and economic well-being
b. Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
c. Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance abuse is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases." Tobacco addictions are included in this definition.

Substance Abuse Treatment Program Services

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

Summary Health Information

Information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom Plan Sponsor has provided health benefits under the Plan. The information described in 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

Syngeneic Transplant

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

Tandem Transplant

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

T-Cell Depleted Infusion

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

Technical Surgical Assistance

Professional active assistance given to the operating physician during surgery by another physician not in charge of the case. Professional active assistance requires direct physical contact with the patient.

Telemedicine

Real-time health care services, delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Contact for these services can be initiated by you or your provider, and must be within your provider's scope of practice.

Terminally Ill

A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Termination

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

Therapeutic Radiology

The treatment of neoplastic conditions with radiant energy.

Therapeutic Shoes

Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.

Total Body Irradiation

A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Total Disability; Totally Disabled

A physical state of a Covered Person resulting from an Illness or Injury that wholly prevents either of the following activities:

a. A Participant engaging in any and every business or occupation and performing any and all work for compensation or profit.

b. A Dependent performing the normal functions and activities of a person of like age and gender in good health.

Treatment Plan

A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Treatment Plan for Autism Disorders

A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at three, six and/or nine months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

1. The approved autism evaluation center will recommend an initial high-level treatment plan.
2. The board certified behavior analyst will develop a detailed treatment plan specific to applied behavior analysis treatment.

Urgent Care

Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or professional providers' offices.

Valid Application

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

Voluntary Sterilization

Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

Waiting Period

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

Ward

A hospital room with three or more beds.

Well-Baby Care

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

Working Aged

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

Working Disabled

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

You and Yours

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

ELIGIBILITY AND PARTICIPATION – SCHEDULE FOR ELIGIBILITY AND PARTICIPATION

Active Coverage Eligibility Requirements

In order to be eligible to participate in this Plan, an individual must satisfy the following requirements:

a. Be currently employed by the Employer and satisfy the following requirements:

1. Can be identified in one of the following employment classifications:

   A. Working in Full-Time Employment for 40 or more hours per week.
   B. Working in a Part-Time Eligible Position.

2. Have been employed in Full-Time Employment or a Part-Time Eligible Position by the Employer in accordance with the following New Hire Health Plan Eligibility Schedule. Under no circumstances will an individual be allowed to participate in the Plan until he or she is working in Full-Time Employment or classified by the Employer to be working in a Part-Time Eligible Position.

3. As permitted under Health Care Reform and detailed in the Employer's written policies, the Employer will use the Measurement Period/Stability Period Safe Harbor method to determine the eligibility of an Employee who does not work in Full-Time Employment or a Part-Time Position to participate in the Plan. Contact the Employer for more information.

New Hire Health Plan Eligibility Schedule:

Date of Hire	Eligible Date
January 1 through January 31	March 1
February 1 through February 28/29	April 1
March 1 through March 31	May 1
April 1 through April 30	June 1
May 1 through May 31	July 1
June 1 through June 30	August 1
July 1 through July 31	September 1
August 1 through August 31	October 1
September 1 through September 30	November 1
October 1 through October 31	December 1
November 1 through November 30	January 1
December 1 through December 31	February 1

b. Be a Dependent of an Employee who is eligible for and enrolled in the Employer's Medicare Supplemental coverage because of End Stage Renal Disease (ESRD). These individuals may be subject to special rules for eligibility, enrollment, and contributions as described in the Employer's written policies. In the event of a conflict between this document's provisions and the Employer's written policies permitting this coverage, the Employer's policies will rule.

NOTE: An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll for coverage under the Plan as both a Participant and as a Dependent. However, any claims submitted by such individuals would be subject to the Plan's usual Coordination of Benefits provision.

Retiree Coverage Eligibility Requirements

In order to be eligible to participate in this Plan, an individual must satisfy either of the following requirements:

a Be classified by the Employer as a Retiree or surviving Dependent of a deceased Retiree and be eligible for Retiree coverage under the Plan as detailed in the Employer's written policies.

b Be a surviving Dependent of a deceased Retiree and be eligible for Retiree coverage under the Plan as detailed in the Employer's written policies.

c. Be a Dependent of a Retiree who is eligible for and enrolled in the Employer's Medicare Supplemental coverage. These individuals may be subject to special rules for eligibility, enrollment, and contributions as described in the Employer's written policies. In the event of a conflict between this document's provisions and the Employer's written policies permitting this coverage, the Employer's policies will rule.

NOTE: Individuals who are covered under the terms of this section and the Retiree Coverage section will generally no longer be eligible for coverage under the Plan upon becoming enrolled in the Employer's Medicare Supplemental coverage. See the Retiree Coverage section for more details.

Participant Effective Date

Participation in the Plan will start for new Employee applicants on the date on which they meet the Active Coverage Eligibility Requirements stated above. Participation in the Plan will start for new Retiree applicants on the first of the month following the date on which they meet the Retiree Coverage Eligibility Requirements stated above. Both Employee and Retiree applicants must also meet the requirements described in the Participant Enrollment section below.

Employer-Provided Extensions of Participation

NOTE: The Short-Term Disability Leave Extension of Participation will be in addition to the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation. Any other Employer-provided extension of participation (except to the extent that it is also a Family and Medical Leave Act of 1993 [FMLA] extension of participation) will be offset against the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation.

Short-Term Disability Leave Extension of Participation..... Up to 180 days*

Long-Term Disability Leave Extension of Participation.....Through the end of the month in which the first 180 days of the Long-Term

Disability is exhausted*

* If a Participant exhausts the Short-Term Disability Leave Extension of Participation, he or she may be eligible for continued coverage under the Long-Term Disability Leave Extension of Participation provided the approved disability leave continues.

Approved Leave of Absence Without Pay Extension of Participation .....For the duration of the approved leave, provided the Employee makes any required monthly Plan payments

Military Leave Extension of Dependent Participation.....Dependents of an Employee on a military leave will be covered for the duration of the Employee's military leave pursuant to Board of Commissioners' Resolution #08270

Parental Leave……Up to 6 weeks (240 hours) ..... pursuant to Board of Commissioners' Resolution #16137

Annual Open Enrollment Period..... **Employees**: September and October*: **Retirees**: February 1 through January 31

* Generally, the above-stated Annual Open Enrollment Period will apply to all Employees. However, other open enrollment periods may occur periodically as required by collective bargaining agreements.

Reinstatement.....As required as a result of a Personnel Appeal Board Decision, Arbitrator 's Award, or Judicial Directive

Retiree Coverage..... Yes, for those eligible

INITIAL REQUIREMENTS

Participant Eligibility

A person is eligible for Participant Coverage under the Plan if the person meets all of the Participant eligibility requirements listed in the Schedule for Eligibility and Participation.

Participant Enrollment

A person who is eligible for Participant Coverage on the effective date of this Plan is a Covered Person as of the effective date if that person has made written application for Participant Coverage before the effective date. For every other person, Participant Coverage begins on the first of the month following the date on which the person meets both of the following requirements:

a. The person is eligible for Participant Coverage.

b. The person has made written application for Participant Coverage on a form acceptable to the Plan Administrator on or before the first date on which coverage could begin. For more details on the Plan's eligibility waiting period for new hires, refer to the Active Coverage Eligibility Requirements section for the New Hire Health Plan Eligibility Schedule.

If application for Participant Coverage is not made by the date coverage could begin, the Employer will automatically enroll the Participant in an assigned benefit program. Unless the Employee formally notifies the Employer that he or she is declining coverage by the coverage start date, the Participant may not waive the assigned benefit program. Enrollment in the assigned benefit program shall remain in effect until the last day of the Plan Year unless the Participant experiences special enrollment rights.

If the applicant declines coverage on or before the first date on which coverage could begin, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

a. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

   1. The other coverage was COBRA, and it has been exhausted.
   2. The applicant became ineligible (i.e., as a result of a Change in Status).
   3. Employer contributions for the coverage have been terminated.
   4. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).
   5. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).
   6. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).
   7. A plan's lifetime limit on all benefits was applied.

   Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

b. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.

c. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

d. The applicant experiences a change (other than those described above) that would permit a mid-year election change in accordance with the rules established by Section 125 of the Code.

An applicant with special enrollment rights must make application for Participant Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage; marriage, birth, adoption, or placement for adoption (whichever is applicable); or the Section 125-permitted election change event. However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Participant Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, or the Section 125-permitted election change event.

An applicant with special enrollment rights who fails to make application for Participant Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

All Participant Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

Dependent Eligibility

A person is eligible for Dependent Coverage under the Plan when both of the following requirements are met:

a. The person is a Dependent.

b. The Participant on whom the person is dependent is eligible for Participant Coverage. However, this requirement shall not apply to a surviving Dependent of a deceased Retiree or a Dependent of an Employee or Retiree who is enrolled in the Employer's Medicare Supplemental coverage.

Dependent Enrollment

A person who is eligible for Dependent Coverage on the effective date of this Plan is a Covered Person as of the effective date if the Participant makes written application for Dependent Coverage before the effective date. For every other person, except for a surviving Dependent of a deceased Retiree or a Dependent of an Employee or Retiree who is enrolled in the Employer's Medicare Supplemental coverage (these individuals will instead be subject to the enrollment requirements specified in the Employer's written policies), Dependent Coverage begins when all of the following requirements are met:

a. The person is eligible for Dependent Coverage.
b. The Participant on whom the person is dependent is a Covered Person.
c. The Participant makes a written application for Dependent Coverage on a form acceptable to the Plan Administrator on or before the first date that coverage could begin. This requirement does not apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption, during the placement of the Dependent for adoption, or legal guardianship). For these Dependents, see the next paragraph below.

   Notwithstanding the immediately preceding paragraph, the following special rules apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption):

   1. A Participant's spouse may be enrolled as a Dependent as of the date of marriage if written application for Dependent Coverage for the spouse is made within 30 days of the date of marriage.
   2. A Participant's Newborn will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. The provision shall not apply to, nor in any way affect, the maternity provisions of this Plan, if any, applicable to the mother.
   3. If a Dependent is acquired other than at the time of the Dependent's birth on account of marriage, or a court order or decree, that Dependent may be enrolled as a Dependent as of the date of the marriage, court order or decree, if written application for Dependent Coverage for the new Dependent is made within 30 days of the court order, decree, or marriage. Dependent Coverage for a child to be placed with a Participant through adoption is effective as of the date the child is placed for adoption, if written application for Dependent Coverage for the child is made within 30 days of the child's placement. A child is considered placed for adoption if the Participant has a legal obligation for total or partial support of the child in anticipation of the child's adoption.

   If application for Dependent Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

   1. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

      A. The other coverage was COBRA, and it has been exhausted.
      B. The applicant became ineligible (i.e., as a result of a Change in Status).
      C. Employer contributions for the coverage have been terminated.

D. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

E. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

F. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).

G. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

2. The applicant has acquired a new Dependent by marriage, birth, adoption, placement for adoption, or legal guardianship. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, placement for adoption, or legal guardianship.

3. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

4. The applicant experiences a change (other than those described above) that would permit a mid-year election change in accordance with the rules established by Section 125 of the Code.

An applicant with special enrollment rights must make application for Dependent Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage; marriage, birth, adoption, placement for adoption (whichever is applicable); the Section 125-permitted election change event; or legal guardianship. However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Dependent Coverage shall be effective as of the date of the loss of other coverage; the marriage, birth, adoption or placement for adoption; the loss of Medicaid or CHIP eligibility; or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy); the Section 125-permitted election change event; or legal guardianship.

An applicant with special enrollment rights who fails to make application for Dependent Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

The requirement to make written application for a Newborn Dependent is waived.

Except for Newborn coverage, which shall begin at the moment of birth, Dependent Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

SWITCHING COVERAGE STATUS

If a Dependent is eligible to be enrolled as a Participant, enrollment may be effective on the date of the enrollment. If a Participant is eligible to be enrolled as a Dependent, enrollment may be effective on the date of the enrollment. Any switches in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage.

PARTICIPANT CONTRIBUTION

The Employer may require a contribution from Participants (or a Dependent if covered separately from a Participant in accordance with the Plan's provisions permitting such coverage) in order to maintain Employee participation and/or the participation of any Dependents in the Plan. If Participant contributions are required, the Employer will notify the Participants of the designated amount. If the Employer maintains a Section 125 Plan, the required contributions may be paid on a pre-tax basis under that plan.

ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in September and October each year for eligible individuals and their dependents to elect coverage under this Plan for the following Plan Year. Eligible individuals (e.g., Employees working in Full-Time Employment and Part-Time Eligible Position who have satisfied the initial participation eligibility requirements and who continue to be eligible) may make elections during the Annual Open Enrollment Period to elect coverage for the subsequent Plan Year with a January 1 effective date of coverage.

The Plan will also offer a 12-month Annual Open Enrollment Period from February 1 to January 31 each year for eligible Retirees and their dependents to elect coverage under this Plan as a Retiree for the following Plan Year. For those Retirees and their dependents who are eligible to enroll during the Annual Open Enrollment Period, their effective date of coverage would be January 1 following the Annual Open Enrollment Period election, except in the case of any elections made in January. In the event a Retiree elects coverage under the Plan during the month of January, the effective date of coverage for that Retiree and their eligible dependents would be the January 1 coincident with or immediately prior to the election.

Other open enrollment periods may occur periodically as required by collective bargaining agreements.

TERMINATION OF COVERAGE

Participant Termination

Participant Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation or Retiree Coverage provisions:

a. Through the end of the month in which the Participant's employment terminated.

b. Through the end of the month in which the Participant goes on a leave of absence.

c. Through the end of the month in which the Participant ceases to be in a classification (e.g., Full-Time Employment or Part-Time Eligible Position) shown in the Schedule for Eligibility and Participation.

d. The last day of the period for which the Participant fails to timely make any required contribution for coverage.

e. Date on which the Plan is terminated; or with respect to any benefit(s) of the Plan, the date of termination of such benefit(s).

f. Through the end of the month in which the Plan Administrator terminates the Participant's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits.

g. Through the end of the month in which the Participant provides notice of voluntary withdrawal. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, such contributions will continue to be assessed through the end of that plan's plan year unless the voluntary withdrawal occurs during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

h. Date of the Participant's death. However, the Plan will continue to cover any surviving Dependents through the end of the month in which the death occurs (see Dependent Termination section below).

Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

Reinstatement

Reinstatement is not available under this Plan, except as required by law, as required by a Personnel Appeal Board Decision, or pursuant to a judicial or quasi-judicial proceeding. Accordingly, a veteran's right and entitlement to reinstatement on returning from military training or service shall be governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), and any other applicable laws or regulations. Further, see the Family and Medical Leave Act of 1993 (FMLA) section below regarding the right to reinstatement upon return to work from an FMLA leave. The Plan will also allow reinstatement in accordance with the break-in-service provisions set forth in Health Care Reform's employer shared responsibility provisions. Otherwise, a Participant whose coverage terminates and who resumes working in Full-Time Employment or a Part-Time Eligible Position with the Employer will be considered a new Employee for purposes of determining when coverage begins, subject to the guidelines under the Affordable Care Act.

Dependent Termination

Dependent Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation or Retiree Coverage provisions:

a. Except in the case of a Dependent child reaching the maximum age of eligibility (as further discussed in provision B. below), through the end of the month if the Dependent ceases to be a Dependent as defined in the Definitions section. However, in no event will a Participant's ex-spouse or step-child remain covered after the date of the Participant's divorce or legal separation (i.e., coverage for these individuals will always end on the date the divorce or legal separation occurs).

b. Through the end of the Calendar Year in which a Dependent child turns 26 years of age.

c. Except as otherwise provided for in provision I. below, date of termination of the Participant's coverage under the Plan. A Participant's coverage will generally be maintained through the end of the month in most termination situations (see Participant Termination section above for more details).

d. The last day of the period for which the Participant fails to make any required contributions for Dependent Coverage in a timely manner.

e. Through the end of the month in which the Plan Administrator terminates the Dependent's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation.

f. Date on which the Plan or a benefit of the Plan is terminated.

g. Through the end of the month in which notice of voluntary withdrawal is made by or on behalf of the Dependent. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, a voluntary withdrawal may occur only during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

h. Through the end of the month in which the Employee or Retiree on whom the person is dependent terminates coverage under the Employer's Medicare Supplemental coverage.

i. Date of the Dependent's death.

j. Through the end of the month in which the Participant's death occurs.

The Participant is obligated to immediately report to the Plan Administrator any change that would result in a Dependent's termination of coverage. Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

RETIREE COVERAGE

The Plan will allow any eligible Participant who satisfies the requirements specified in the Retiree Coverage Eligibility Requirements section and meets the definition of a Retiree to elect group health coverage for him or herself and any eligible dependent(s). Further, any surviving Dependents of a deceased Retiree are also eligible for Retiree coverage under the Plan as specified in the Retiree Coverage Eligibility Requirements section. In general, surviving Dependents will be subject to the Plan's usual eligibility and termination provisions without regard to any Participant- or Retiree-related provisions that could not apply.

Participant contributions for Retiree coverage will vary based on a Retiree's classification, years of service status with the Employer, and/or coverage election (Retiree-only coverage or Family coverage).

If a Retiree or a Retiree's Dependent becomes eligible for Medicare for any reason other than End Stage Renal Disease (ESRD), that individual must enroll for Medicare Part A and Part B at the first available opportunity to do so. If the individual is eligible for Medicare owing to ESRD, the Plan will remain the primary payer for the period of time prescribed by law until such time that Plan coverage is terminated for another reason. Upon the expiration of this period of time prescribed by law, coverage under the Plan will terminate.

The Employer should immediately be notified when a Covered Person becomes eligible for or enrolled in Medicare. A failure to notify the Employer of a change in Medicare eligibility or enrollment as soon as possible may result in the Plan Administrator determining that the Covered Person committed fraud or intentional misrepresentation in a claim for benefits and, accordingly, could result in an immediate termination of the Covered Person's coverage and/or the Covered Person may be asked to reimburse the Plan for any overpaid amounts.

As specified above, when a Retiree or a Retiree's Dependent spouse or child becomes eligible for Medicare due to age or disability, that individual must immediately notify the Employer of his or her Medicare eligibility or enrollment. Once the Employer is made aware of a Covered Person's Medicare eligibility or enrollment, coverage under the Plan for that person will then terminate as of the date of the first applicable event described below:

a. Enrollment in the Employer's Medicare Supplemental coverage/plan.

b. 90 days following the initial date the individual became eligible for Medicare but fails to enroll in Medicare during the Medicare Initial Enrollment Period (IEP) or the Medicare Special Enrollment Period (SEP).

c. At the expiration of Medicare's General Enrollment Period (GEP) if the individual fails to enroll during this period.

For an individual who enrolls in Medicare during an SEP or the GEP, the Retiree coverage provided under the Plan will continue until that individual is awarded Medicare A and B benefits as prescribed by Social Security Administration regulations.

The Employer reserves the right to amend Retiree coverage at any time.

EXTENSIONS OF PARTICIPATION

A Participant may have participation extended under Employer-provided extensions specified in the Schedule for Eligibility and Participation, under the FMLA, or under COBRA. A Long-Term Disability Leave Extension of Participation will offset the length of a COBRA extension of participation; in the event that this Employer-provided extension of participation ever runs concurrently with an FMLA extension of participation, the COBRA extension of participation will proceed after the FMLA extension of participation ends. Any other Employer-provided extension of participation, including a Short-Term Disability Leave Extension of Participation will apply before a COBRA extension of participation and will be in addition to the length of a COBRA extension of participation.

Notwithstanding any of the following provisions concerning extensions of participation, coverage for the Participant or the Participant's Dependent(s) may be immediately reduced or terminated by amendment to the Plan or termination of the Plan. If an event causing the Participant's or the Dependent's coverage to terminate also causes another extension of participation, a new extension period will begin for the Participant or the Participant's Dependent(s) on the date of such event.

Provided any required contributions are paid, coverage during an Employer-provided extension of participation shall be continued on the same basis as if the Participant had continued in Active Employment for the duration of the leave (note that Plan coverage may not be provided for the duration of an Employee's long-term disability leave, which can extend, if permitted by the Employer's policies, beyond the time period specified in Schedule for Eligibility and Participation).

Employer-Provided Extensions of Participation

a. **Short-Term Disability Leave Extension**

Participation for a Participant and any eligible Dependents continues if the Participant suffers from Illness or Injury and has been granted a disability leave by the Employer's disability carrier under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved disability leave begins. However, if the Participant's disability leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation, the expiration of the approved disability leave or termination of employment, whichever occurs first.

b. **Long-Term Disability Leave Extension**

Participation for a Participant and any eligible Dependents continues if the Participant suffers from Illness or Injury and has been granted a disability leave by the Employer's disability carrier under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. Provided the Participant's approved disability leave continues, this extension of participation begins on the date immediately following the exhaustion of the time period established for the Short-Term Disability Leave Extension of Participation as stated in the Schedule for Eligibility and Participation. If the Participant's disability leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the

Schedule for Eligibility and Participation or the expiration of the approved disability leave, whichever occurs first.

c. **Approved Leave of Absence Without Pay Extension**
Participation for a Participant and any eligible Dependents continues if the Participant is granted an approved leave of absence (other than a disability leave described in the above paragraph) by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved leave of absence begins. However, if the Participant's approved leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation, the expiration of the approved leave of absence, or failure to pay required contributions, whichever occurs first.

d. **Military Leave Dependent Extension**
Participation for any eligible Dependents continues if the Participant goes on a military leave in accordance with the Employer's policies established by the Board of Commissioners' Resolution #08270. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation.

e. **Approved Parental Leave**
Participation for a Participant and any eligible Dependents continues if the Participant is granted an approved parental leave of absence by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved parental leave of absence begins. However, if the Participant's approved leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation, the expiration of the approved parental leave of absence.

Family and Medical Leave Act of 1993 (FMLA)

A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in Active Employment continuously for the duration of the leave. Other provisions regarding an FMLA leave are set forth in the FMLA and the Employer's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, the Employer may recover any Employer contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non-payment, subject to the right to reinstatement of coverage upon return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

COBRA and USERRA Extensions of Participation

Certain individuals shall have the right to elect to continue coverage under this Plan upon the occurrence of a COBRA Qualifying Event or if the Participant goes on a military leave and the Uniformed Services Employment and Reemployment Rights Act (USERRA) mandates an extension of coverage. For more information on the COBRA and USERRA (military leave) extensions of participation, access the Employer's website (www.oakgov.com/benefits).

BENEFIT SCHEDULE

The basic deductibles, copayments, coinsurances and benefits for each calendar year payable by the Plan are illustrated in the schedule below. The schedule is only a brief summary and the covered expenses are explained in more detail in the pages that follow.

	In-Network	Out-of-Network
Deductibles	$100 for one member $200 for the family (when two or more members are covered under the Plan)	$250 for one member $500 for the family (when two or more members are covered under the Plan)
Copayment	$20 per office visit, urgent care visit, office consultation and chiropractic visits $100 per emergency room visit, waived if admitted or for accidental injury	30% after out-of-network deductible $100 per emergency room visit, waived if admitted or for accidental injury
Coinsurance (Percent copays)	50% of approved amount for private duty nursing 10% of approved amount for most other covered services	50% of approved amount for private duty nursing 30% of approved amount for most other covered services
Embedded Coinsurance Maximum	$500 for one member $1,000 for the family (when two or more members are covered)	$1,500 for one member $3,000 for the family (when two or more members are covered)
Annual Out-of-Pocket Maximums* Applies to all fixed dollar copays, deductible and coinsurance amounts *Adjusted annually. See www.oakgov.com/benefits for current maximum.	$4,125 for one member $10,250 for the family (when two or more members are covered under the Plan)	$4,125 for one member $10,250 for the family (when two or more members are covered under the Plan)
Inpatient Hospital Care		
Inpatient Hospital (Includes coverage for general conditions, drugs, meals, hospital equipment, special diets and nursing care in a semi-private room or intensive care unit as medically necessary)	90% after in-network deductible	70% after out-of-network deductible
Outpatient Hospital Care		
Emergency Room Care and Medical Emergencies	$100 copay, copay waived if admitted or for accidental injury	$100 copay, copay waived if admitted or for accidental injury
Outpatient Physical Therapy, Speech Therapy and Occupational Therapy	90% after in-network deductible	70% after out-of-network deductible
Maximum visits per member per calendar year	60 combined visits; visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied to this maximum	
Urgent Care		
Urgent Care	$20 copay	70% after out-of-network deductible

Routine Preventive Care		
Routine Health Maintenance Examination or Physical*	Covered 100%, no deductible	Not covered
Routine Gynecological Exam	Covered 100%, no deductible	Not covered
Routine Pap Smear Screening – laboratory and pathology services	Covered 100%, no deductible	Not covered
Well-Baby Child Care* • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the Health Maintenance Exam benefit	Covered 100%, no deductible	Not covered
Routine Immunizations, Routine X-Rays and Labs, and Other Routine Services	Covered 100%, no deductible	Not covered
Routine Mammograms**	Covered 100%, no deductible	Covered 100% of BCBSM approved amount, no deductible
Colonoscopy – Routine or Medically Necessary**	Covered 100%, no deductible	Covered 100% of BCBSM approved amount, no deductible
FDA-Approved Contraceptive Methods for Women with Reproductive Capacity		
Contraceptive Injections (includes both substance and administration charges)	Covered 100%, no deductible	70% after out-of-network deductible
Contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	Covered 100%, no deductible	Covered 100% after out-of-network deductible
Sterilization Procedures for Women with Reproductive Capacity	Covered 100%, no deductible	Not covered

* *The Plan applies specific frequency limitations to Routine exams, including well-baby and Routine child care visits if a nonparticipating provider charges more than the approved amount, then you are responsible for the difference.*

** *The first mammogram performed for Routine screening purposes and the first colonoscopy, whether performed for Routine or diagnostic purposes, in any Plan Year will be paid under this benefit (subject to the applicable above-stated benefit percentage). All charges incurred in connection with a diagnostic mammogram or any subsequent Routine/diagnostic colonoscopies or Routine mammograms (or charges related to diagnostic mammograms or subsequent Routine/diagnostic colonoscopies or Routine mammograms) incurred in a Plan Year will not be covered under this benefit, but instead will be paid the same as any other Illness (subject to applicable Deductible, if any, and general benefit percentage.*

Note:

1. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.
2. This benefit provides coverage for certain Routine immunizations administered at an In-Network Physician's office or by a Public Health Department. Covered Routine immunizations administered by a Public Health Department will be payable at the In-Network benefit level.

Mental Health and Substance Abuse Care		
Inpatient Mental Health	90% after in-network deductible	70% after out-of-network deductible
Outpatient Mental Health	90% after in-network deductible If office visit: $20 copay	10% after out-of-network deductible If office visit:70% after out-of-network deductible
Inpatient Substance Abuse Care	90% after in-network deductible	70% after out-of-network deductible
Outpatient Substance Abuse Care – in approved facilities only	90% after deductible If office visit: $20 copay	70% after out-of-network deductible (in-network cost sharing will apply if there is no PPO network)
Special Hospital Programs		
Hospice Care	Covered 100%, no deductible	Covered 100%, no deductible
Specified Human Organ Transplants	Covered 90-100%, no deductible according to plan guidelines	Covered 100%, no deductible (in designated facilities only)
Medical and Surgical Care		
Surgery	90% after in-network deductible	70% after out-of-network deductible
Technical Surgical Assistant	90% after in-network deductible	70% after out-of-network deductible
Anesthesia	90% after in-network deductible	70% after out-of-network deductible
Maternity Care	90% after in-network deductible	70% after out-of-network deductible
Delivery	90% after in-network deductible	70% after out-of-network deductible
Pre- and Post-Natal Care	Covered 100%, no deductible	70% after out-of-network deductible
Inpatient Medical Care	90% after in-network deductible	70% after out-of-network deductible
Inpatient Consultations	90% after in-network deductible	70% after out-of-network deductible
Outpatient/Freestanding Laboratory and Pathology	90% after in-network deductible	70% after out-of-network deductible
Diagnostic Services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic and Therapeutic Radiology	90% after in-network deductible	70% after out-of-network deductible

Additional Benefits		
Office Visits	$20 copayment, then 100%	70% after out-of-network deductible
Chiropractic Care		
Physician's Fee for an Initial or Periodic Evaluation, Spinal Manipulations, and Therapy Treatments	$20 copayment per day, then 100%	70% after out-of-network deductible
	Limited to 24 visits per calendar year. Visits with in-network and out-of-network providers count toward this maximum.	
Diagnostic Spinal X-Rays	90% after in-network deductible	70% after out-of-network deductible
Maximum number of chiropractic visits (for this purpose, a "visit" means all chiropractic services rendered by one provider in a day) allowed per member per calendar year	24	
Allergy Testing	Covered 100%, no deductible	70% after out-of-network deductible
Allergy Therapy	Covered 100%, no deductible	70% after out-of-network deductible
Ambulance Transportation	90% after in-network deductible	90% after in-network deductible
Durable Medical Equipment (DME), Prosthetics, and Orthotics	90% after in-network deductible	90% after in-network deductible
Note: Certain DME items are required by Health Care Reform to be covered under the Plan's Routine Preventive Care benefit. Accordingly, when such items are received from an In-Network Provider, these charges will be processed as a Routine Preventive Care expense and subject to no cost-sharing.		
Diabetic Supplies (Includes syringes, lancets, lancet devices, alcohol swabs, test strips, insulin pumps, glucose monitors, and other Medically Necessary diabetic supplies; Physician's prescription is required.)	90% after in-network deductible	70% after out-of-network deductible
Private Duty Nursing	50% after in-network deductible	50% after out-of-network deductible
Skilled Nursing	90% after in-network deductible	90% after in-network deductible
Autism Spectrum Disorder Services		
Autism Spectrum Disorder Treatment (including, but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)	90% after in-network deductible	70% after out-of-network deductible
Applied Behavioral Analyses (ABA) Treatment	90% after in-network deductible	70% after out-of-network deductible

The following chart highlights the differences in payment between In-Network and Out-of-Network.

<table>
<tr><th colspan="3">Choosing Your Provider</th></tr>
<tr><th>If you receive services from an In-Network Provider</th><th colspan="2">If you receive services from an Out-of-Network Provider</th></tr>
<tr><td>Provider accepts the BCBSM approved amount as payment in full.</td><td>Participating Provider*
This Out-of-Network Provider participates with BCBSM.</td><td>Nonparticipating Provider*
This out-of-network provider chooses not to participate with BCBSM.</td></tr>
<tr><td>You will pay the least out-of-pocket costs:
a. Lower deductible.
b. Lower copayment and coinsurance amounts.
c. No copayment or coinsurance for certain preventive care benefits.
No claim forms to file.</td><td>Provider accepts the BCBSM approved amount as payment in full.
You will pay more out-of-pocket costs than what you pay if you see an in-network provider (unless you are referred by a PPO in-network provider):
a. Higher deductible, unless noted.
b. Increased out-of-network copayment and coinsurance amounts.
c. No deductible, copayment or coinsurance for certain preventive care benefits.
No claim forms to file.</td><td>Provider does not accept the BCBSM approved amount as payment in full.**
You will pay the highest out-of-pocket costs (unless you are referred by a PPO in-network provider):
a. Higher deductible.
b. You pay all charges that exceed the amount The Plan pays for a service.
c. Increased copayment and coinsurance amounts unless noted.
You must file claim forms.</td></tr>
<tr><td colspan="3">* Important: A provider can either be participating or nonparticipating. Participating providers cannot bill you for more than the Plans payment plus what you pay in cost-sharing. Nonparticipating providers can bill you for the amount that is more than what The Plan pays plus out-of-network cost-sharing.
**Some nonparticipating providers participate on a per claim basis. That is, they accept BCBSM’s payment on a one-time basis. You must also pay the out-of-network cost-sharing.</td></tr>
</table>

COMPREHENSIVE MEDICAL BENEFITS

Deductible

a. **In-Network Providers**

Each calendar year, you must pay a deductible for in-network covered services.

1. $100 for one member.
2. $200 for the family (when two or more members are covered under your contract).

    A. Two or more members must meet the family deductible.
    B. If the one member deductible has been met, but not the family deductible, the Plan will pay for covered services only for that member who has met the deductible.
    C. Covered services for the remaining family members will be paid when the full family deductible has been met.

Payments applied to your in-network deductible in the last three months of a calendar year will be applied toward your in-network deductible requirement for the next calendar year.

Payments applied to your out-of-network deductible also count toward your in-network deductible. However, payments applied to your in-network deductible do not count toward your out-of-network deductible.

You are not required to pay a deductible for the following:

1. Covered services performed in an in-network physician's office, including mental health and substance use disorder services that are equal to an office visit, presurgical consultations.
2. Services subject to a copayment requirement.
3. Professional services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.
4. Osteopathic manipulation
5. Chiropractic manipulation.
6. Prenatal and postnatal care visits.
7. Allergy testing and therapy.
8. Therapeutic injections.
9. Hospice care benefits.
10. Preventive care services.

The Plan will not apply charges toward your in-network deductible if one of the following applies:

1. The charges exceed the Plan’s approved amount.
2. The charges are for non-covered services

b. **Out-of-Network Providers**

Each calendar year, you must pay a deductible for out-of-network covered services:

1. $250 for one member
2. $500 for the family (when two or more members are covered under your contract)

    A. Two or more members must meet the family deductible.

B. If the one member deductible has been met, but not the family deductible, the Plan will pay covered services only for that member who has met the deductible.
C. Covered services for the remaining family members will be paid when the full family deductible has been met.

Payments applied to your out-of-network deductible also count toward your in-network deductible. However, payments applied to your in-network deductible do not count toward your out-of-network deductible.

You do not have to pay an out-of-network deductible for:

1. Services provided by an out-of-network provider when an in-network provider has referred you. You must obtain the referral prior to receiving the referred services; otherwise, or the service will be subject to your out-of-network deductible
2. Professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
3. Services from a provider for which there is no PPO network
4. Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, you may not have to pay an out-of-network deductible for:

1. Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
2. The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

If one of the above applies and you do not have to pay the out-of-network deductible, you may still need to pay the in-network deductible.

You may contact BCBSM for information regarding these professional services.

Copayment and Coinsurance Requirements

a. **In-Network Providers**

In addition to your deductible, you must pay the following coinsurance for covered services by in-network providers:

1. $100 copayment per visit for facility services in a hospital emergency room. The $100 copayment is not applied if:
   A. The patient is admitted or
   B. Services were required to treat an accidental injury

   Copayments are not applied to emergency services received from physicians, whether in-network or out-of-network, for treatment for a medical emergency or accidental injury.

2. $20 copayment per office visit **except** for:
   A. First aid and medical emergency treatment
   B. Prenatal and postnatal care visits
   C. Allergy testing and therapy

D. Therapeutic injections
E. Presurgical consultations

3. 50 percent of the approved amount for private duty nursing care.

4. 10 percent of the approved amount for most other covered services.
This 10 percent coinsurance does not apply to:

A. Services in an in-network physician's office, except mental health and substance abuse services that are not equal to an office visit. These services will require payment of your coinsurance.
B. Services subject to a copayment requirement
C. Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
D. Prenatal and postnatal care visits
E. Allergy testing and therapy
F. Therapeutic injections
G. Hospice care benefits
H. Preventive care services
I. Presurgical consultations

b. **Out-of-Network Providers**
You must pay the following copayment amounts for covered services by out-of-network providers:

1. $100 copayment per visit for facility services in a hospital emergency room. The $100 copayment is not applied if:

A. The patient is admitted or
B. Services were required to treat an accidental injury
You do not have to pay a copayment for physician services, in- or out-of-network, for treatment for a medical emergency or accidental injury. However, if you receive services from a non-participating provider, you may have to pay the difference between what the Plan pays and the provider’s charge.

2. 50 percent of the approved amount for private duty nursing care
3. 30 percent of the approved amount for most other services

You will not be required to pay the 30 percent coinsurance for covered out-of-network services when:

1. An in-network provider refers you to an out-of-network provider
You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network coinsurance requirements
2. You receive facility and professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
3. A female member of your contract obtains a prescription contraceptive device from an out-of- network provider
4. You receive services from a provider for which there is no PPO network
5. You receive services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty

In limited instances, out-of-network copayment requirements may not be imposed for:

1. Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
2. The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

While the out-of-network copayment requirements may not be imposed, covered services will be subject to applicable in-network copayment requirements (if any).

You may contact BCBSM for information regarding these professional services.

The Plan will not apply charges toward your copayments that:

1. Exceed the Plans approved amount or
2. Are for non-covered services

Benefit-Specific Cost-Sharing Requirements

Certain benefits have specific cost-sharing requirements as follows.

a. **Chiropractic and Osteopathic Manipulation Therapy**
When received in-network, you must pay a $20 copayment for each chiropractic or osteopathic manipulative treatment. These are for services given in a physician's office. If out-of-network, you pay out-of-network cost-sharing. When an office visit and manipulative treatment service is billed on the same day, by the same in-network physician, only one copayment will be required for the office visit.

b. **Contraceptive Devices**
When received in-network, you do not pay any cost-sharing. When out-of-network, you must pay your out-of-network deductible but no other cost-sharing.

c. **Contraceptive Injections**
When received in-network, you do not pay any cost-sharing. When out-of-network, you must pay your out-of-network cost-sharing.

d. **Hospice Services**
You do not pay any cost-sharing for hospice services from approved physicians, facilities and other approved providers.

e. **Mental Health Services and Substance Abuse Treatment**
You pay the same cost-sharing for mental health services and substance use disorder treatment that you would for all other covered services, in-network or out-of-network.

BCBSM considers some mental health and substance use disorder services to be in the same category as a physician's office visit. When that is the case, you only pay what you would for an office visit.

This means that when you go to an in-network provider, you pay your in-network copayment for the visit. Likewise if you go to an out-of-network provider, you pay your out-of-network deductible and coinsurance.

f. **Outpatient Diabetes Management Program (ODMP)**
Under the ODMP, the Plan pays to train you to manage your diabetes, when needed.
a. When received in-network, you pay no cost-sharing

b. When out-of-network, you pay out-of-network cost-sharing.

For all other services and supplies you get under the ODMP, you do pay cost-sharing. You pay either in-network or out-of-network cost-sharing, depending on the provider you choose

g. **Presurgical Consultations**

When received in-network, you do not pay any cost-sharing for consultations.

h. **Specified Organ Transplants**

If you need an organ transplant that the Plan covers, the entire period of time it takes place is called the benefit period. During this time, you pay no cost-sharing.

i. **Value Based Programs**

When received in-network, you do not pay a deductible, copayment, or coinsurance for "care management" services. These services include:

a. Provider-Delivered Care Management
Services obtained only in Michigan from providers designated by BCBSM

b. Blue Distinction Total Care
Services obtained outside of Michigan from providers designated by the local Blue Cross Blue Shield plan in that state.

j. **Voluntary Sterilization for Females**

The plan pays for voluntary sterilizations for females. The Plan covers services from a physician and in a hospital.

a. When received in-network, you pay no cost-sharing.
b. When out-of-network, you pay out-of-network cost-sharing.

Embedded Coinsurance Maximums

a. **Embedded Coinsurance Maximums for In-Network Services**

Your annual embedded coinsurance maximum per calendar year for covered in-network services is:

1. $500 for one member.
2. $1,000 for the family (when two or more members are covered under your contract).

    A. Two or more members must meet the family embedded coinsurance maximum.
    B. If the one member embedded coinsurance maximum has been met, but not the family embedded coinsurance maximum, the Plan will not require any more coinsurance cost-sharing amounts for that member the remainder of the calendar year.
    C. Coinsurance cost-sharing for the remaining family members will be required until the full family annual embedded coinsurance maximum has been met.

b. **Embedded Coinsurance Maximums for Out-of-Network Services**

Your annual out-of-pocket maximum per calendar year for covered out-of-network services is:

1. $1,500 for one member.
2. $3,000 for the family (when two or more members are covered under your contract).

    A. Two or more members must meet the family embedded coinsurance maximum.
    B. If the one member embedded coinsurance maximum has been met, but not the family embedded coinsurance maximum, the Plan will not require any more

coinsurance cost-sharing amounts for that member the remainder of the calendar year.

C. Coinsurance cost-sharing for the remaining family members will be required until the full family annual embedded coinsurance maximum has been met.

Annual Out-of-Pocket Maximums

a. **Out-of-Pocket Maximums for In-Network Services**

Your annual out-of-pocket maximum per calendar year for covered in-network services is:

1. $4,125 for one member
2. $10,250 for the family (when two or more members are covered under your contract)

   A. Two or more members must meet the family out-of-pocket maximum.
   B. If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, the Plan will not require any more cost-sharing amounts for that member the remainder of the calendar year.
   C. Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.
   D. The maximums noted above are applicable for 2019 only. Subsequent updates to the annual maximums will be noted in an amendment to this document.

The in-network deductible, copayment and coinsurance that you pay are **combined** to meet the annual in-network out-of-pocket maximum

b. **Out-of-Pocket Maximums for Out-of-Network Services**

Your annual out-of-pocket maximum per calendar year for covered out-of-network services is:

1. $4,125 for one member.
2. $10,250 for the family (when two or more members are covered under your contract).

   A. Two or more members must meet the family out-of-pocket maximum.
   B. If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, the Plan will not require any more cost-sharing amounts for that member the remainder of the calendar year.
   C. Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.
   D. The maximums noted above are applicable for 2017 only. Subsequent updates to the annual maximums will be noted in an amendment to this document.

The out-of-network deductible, copayment and coinsurance that you pay are **combined** to meet the annual out-of-network out-of-pocket maximum.

Your cost-sharing requirements under your freestanding prescription drug coverage do not contribute to the annual in-network and out-of-network maximums stated above. There is a separate out-of-pocket maximum you will need to meet for those prescription drug services. Details about this separate Maximum Out-of-Pocket are not discussed in this Plan document; contact Oakland County for more information.

Cost-sharing amounts applied toward the annual out-of-pocket maximum for out-of-network services also count toward the out-of-pocket maximum for in-network services. However, amounts applied toward the in-network out-of-pocket maximum do not count toward the out-of-network out-of-pocket maximum.

Once these amounts are satisfied, all covered benefits under this Plan will be covered at 100% of the approved amount for the remainder of the calendar year.

Affordable Care Act Out-of-Pocket Maximum Limits on Cost-Sharing Requirements

As a result of the Affordable Care Act (ACA), all health plans (including prescription coverage) will be submit to maximum out-of-pocket limits. The ACA defines cost-sharing as deductibles, coinsurance, copayments or similar charges, and any other expenditures required of an individual which is a qualified medical expense with respect to an essential health benefit covered by the plan. Cost-sharing does not include contributions, premiums, balance-billing for non-participating providers, or spending for non-covered services.

In order to comply with this requirement (and as allowed by the ACA), the County assigns a portion of the annual out-of-pocket maximum to the prescription drug plan and the remaining portion to the medical plan. This limit is adjusted annually as a result of the ACA. The current years limit can be obtained on the www.ocbenefits.com or www.oakgov.com/retirement websites.

Maximums for Days of Care or Visits

If annual maximums (days or visits) or lifetime maximums (days or visits) apply for specific services, they are described elsewhere in this SPD.

COVERED SERVICES

This section describes the services the Plan pays for and the extent to which they are covered. The Plan pays for admissions and services when they are provided according to this SPD. Some admissions and services must be approved by BCBSM before they occur. Emergency services do not need to be preapproved. You should call BCBSM Customer Service for a list of admission and services requiring preapproval. Payment will be denied if preapproval is not obtained. The Plan pays only for "medically necessary" services. This includes services that may not be covered under this Plan but are part of an approved treatment plan.

There are exceptions to this rule, such as:

- Voluntary sterilization
- Screening mammography
- Preventive care services
- Contraceptive services

The Plan will not pay for medically necessary services in an inpatient setting if they can be safely given in an outpatient location or office setting. That Plan will pay the approved amount for the services you receive that are covered in this SPD. You must pay your cost share for many of the benefits listed.

The Plan pays for services received from:

Hospital and Other Facilities

The Plan pays for covered services you receive in hospitals and other BCBSM-approved facilities. Your attending physician must prescribe the services before The Plan will cover them. Emergency services do not need to be preapproved by your attending physician.

Physicians and Other Professional Providers

Covered services must be provided by BCBSM-approved providers who are legally qualified or licensed to provide them. Some physicians and other providers do not participate with BCBSM. They do not bill BCBSM, but bill you instead. If you receive services from such a provider while you are in a hospital, the provider may bill you more than what The Plan pays. The Plan will reimburse you the approved amount but you must pay the difference between what The Plan pays and they provider's charge.

Allergy Testing and Therapy

Locations: The Plan pays for allergy testing and allergy therapy in:

a. A participating hospital (inpatient or outpatient)
b. A participating ambulatory surgery facility
c. An office

The Plan pays for:

a. Allergy Testing

1. Survey, including history, physical exam, and diagnostic laboratory studies
2. Intradermal, scratch and puncture tests

3. Patch and photo tests
4. Double-blind food challenge test and bronchial challenge test

b. Allergy Therapy

1. Allergy immunotherapy by injection (allergy shots)
2. Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

The Plan does not pay for:

a. Fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria)
b. Self-administered, over-the-counter drugs
c. Psychological testing, evaluation or therapy for allergies
d. Environmental studies, evaluation or control

Ambulance Services

The Plan pays for:

Ground and air ambulance services to take a patient to a covered destination.

For ground ambulance, a covered destination may include:

a. A hospital
b. A skilled nursing facility
c. A member's home
d. A dialysis center

For air ambulance, a covered destination may include:

a. A hospital
b. Another covered facility, with BCBSM's preapproval

The Plan will pay for a member to be taken to the nearest approved destination capable of providing the level of care necessary to treat the patient's condition. Transfer of the patient between covered destinations must be prescribed by the attending physician.

In every case the following conditions must be met:

a. The service must be medically necessary. Any other means of transport would endanger the patient's health.
b. The Plan only pays for the transportation of the patient and whatever care is required during transport. The Plan does not pay for other services that might be billed with it.
c. The service must be provided in a vehicle licensed as a ground or air ambulance and which is part of a licensed ambulance operation.

The Plan also pays for ground and air ambulance services when:

a. The ambulance arrives at the scene but transport is not needed or is refused.
b. The ambulance arrives at the scene but the patient has expired.

Air Ambulance

Air ambulance services must also meet these requirements:

a. No other means of emergency transportation are available.
b. The patient's condition requires transportation by air ambulance rather than ground ambulance
c. The provider is not a commercial airline
d. The patient is taken to the nearest facility capable of treating the patient's condition

e. Your coverage includes BCBSM's case management program. Air ambulance transportation that does not meet the requirements described above is eligible for review and possible approval under the case management provision of your coverage. Case management may recommend coverage for transportation that positively impacts clinical outcomes, but not for a patient's or family's convenience.

The Plan does not pay for:

a. Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
b. Air ambulance services when the member's condition does not require air ambulance transport

Anesthesiology Services

Locations: The Plan pays for anesthesiology services

a. A participating hospital
b. A participating ambulatory surgery facility
c. An office

The Plan pays for:

a. **Anesthesiology During Surgery**
Anesthesia services given to patients undergoing covered surgery are payable to:
1. A physician other than the operating physician. If the operating physician gives the anesthetics, the service is included in the Plans payment for the surgery.
2. A physician who orders and supervises anesthesiology services
3. A certified registered nurse anesthetist (CRNA)
CRNA services must be:
A. Directly supervised by the physician performing the surgery or procedure or
B. Under the indirect supervision of a physician or anesthesiologist

If a CRNA is an employee of a hospital or facility, we pay the facility directly for the anesthesia services.

c. **Anesthesia During Infusion Therapy**
The Plan pays for local anesthesia only when needed as part of infusion therapy done in an office.
d. **Other Services**
Anesthesia services may also be covered as part of electroconvulsive therapy and for covered dental services

Audiologist Services

Locations: The Plan pays for audiology services performed by an audiologist in:
a. An office
b. Other outpatient locations.

The Plan pays for:
Services performed by an audiologist if they are prescribed by a provider who is legally authorized to prescribe the services.

Cardiac Rehabilitation

Locations: The Plan pays for cardiac rehabilitation in the following locations:

a. A participating hospital

The Plan pays for:

a. Services that begin during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
b. Services given when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required.

The Plan does not pay for:

Services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

Chemotherapy

The Plan pays for chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the prior authorization requirement for Chemotherapy Specialty Pharmaceuticals.

To be payable, the drugs must be:

a. Ordered by a physician for the treatment of a specific type of malignant disease
b. Provided as part of a chemotherapy program and
c. Approved by the Federal Food and Drug Administration (FDA) for use in chemotherapy treatment

If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy department determines the appropriateness of the drug for that disease by using the following criteria:

a. Current medical literature must confirm that the drug is effective for the disease being treated
b. Recognized oncology organizations must generally accept the drug as treatment for the specific disease
c. The physician must obtain informed consent from the patient for the treatment.

The Plan also pays for:

a. Physician services for the administration of the chemotherapy drug, except those taken orally
b. The chemotherapy drug administered in a medically approved manner
c. Other FDA-approved drugs classified as:
    1. Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
    2. Drugs used to enhance chemotherapeutic drugs
    3. Drugs to prevent or treat the side effects of chemotherapy treatment
d. Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports
e. Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines.

f. The plan pays for the outpatient treatment of breast cancer

Chiropractic Services and Osteopathic Manipulative Therapy

Locations: The Plan pays for chiropractic services and osteopathic manipulative therapy in an office.

The Plan pays for:

a. Osteopathic manipulation therapy (OMT) on any location of the body.
b. Chiropractic spinal manipulation (CSM) to treat misaligned or displaced vertebrae of the spine and chiropractic manipulations (CM) to treat other areas of the body allowed by BCBSM
c. The Plan pays up to a combined maximum of 24 visits per member per calendar year for OMT and all CM. Visits with in-network and out-of-network providers count toward this maximum.
d. Chiropractic office visits:

    1. For new patients, the Plan pays for one office visit every 36 months. A new patient is one who has not received chiropractic services within the past 36 months.
    2. For established patients: If your coverage limits the number of medical office visits you may receive, chiropractic office visits also applies to that limit. An established patient is one who has received chiropractic services within the past 36 months.

e. Physical therapy that is part of a physical therapy treatment plan prepared by your chiropractor. The plan must be signed by your M.D. or D.O. **before** you receive physical therapy services for those services to be covered. If a treatment plan is not signed by your M.D. or D.O. before services are rendered, the services will not be covered and you may have to pay for them.

    1. A signed treatment plan is not required for the first physical therapy service your chiropractor performs on you.
    2. Visits for physical therapy are applied toward your 60-visit benefit limit for physical, speech and language pathology, and occupational therapy services.

Any combination of these therapies is limited to a combined maximum of 60 visits (in-network and out-of-network providers combined) per member per calendar year:

    1. Mechanical traction
    2. Physical therapy
    3. Speech and language pathology, and
    4. Occupational therapy

f. Mechanical traction once per day when it is given with CM or CSM. These visits are applied toward your 60 visit limit for physical, speech and language pathology, and occupational therapy services.
g. X-rays when medically necessary.

Chronic Disease Management

Locations: The Plan pays for services to manage chronic diseases in:

a. A participating hospital
b. An office
c. A participating facility
d. A member's home

The Plan pays for chronic disease management services provided by:

a. Participating hospitals
b. Physicians
c. Participating facilities
d. Certified nurse practitioners
e. Certified licensed social workers
f. Psychologists
g. Physical therapists.

Clinical Trials (Routine Patient Costs)

The Plan pays the routine costs of items and services related to clinical trials. The trials may be Phase I, II, III or IV. The purpose of the trial must be to prevent, detect or treat cancer or another life-threatening disease or condition. The member receiving the items or services must be a qualified individual according to the terms of this Plan. Cancer drugs required by Michigan law are covered.

The Plan pays for:

a. All routine services covered under this Plan that would be covered even if the member were not enrolled in an approved clinical trial

You can find the following terms in the Definitions section:

Approved clinical trial
Life-threatening disease
Routine Patient Costs
Qualified individual

The Plan does not pay for:

a. The experimental or investigational item, device or service itself
b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

BCBSM may require you to go to a BCBSM-contracted provider who is already part of an approved clinical trial. An exception would be if the trial is conducted outside of Michigan.

Contraceptive Services

The Plan pays for contraceptive services for women as part of your preventive care benefit.

Dental Services

Locations: The Plan pays for emergency dental care given in:

a. A hospital
b. An ambulatory surgery facility
c. A dentist's office (accidental injuries only)

The Plan pays for other dental services in a participating hospital or provider's office as described below.

The Plan pays for:

a. **Emergency Dental Care**

Emergency dental care is the treatment of accidental injuries within 24 hours of the injury. This is to relieve pain and discomfort. The Plan also pays for follow-up treatment completed within six months of the injury.

A dental accidental injury is when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, gums or bone.

b. **Dental Services in a Hospital**

1. The Plan will pay for dental treatment for a patient in a hospital if the treatment helps improve the medical condition that put the patient in the hospital. The dental condition must be hindering improvement of the medical condition.
2. The Plan may pay for facility and anesthesia services for a patient in a hospital if dental treatment would be unsafe in an office setting. In these cases, The Plan does not pay for the services of the dentist. The Plan only pays for the facility and anesthesia services.

    A. Examples of such medical conditions are:

        1. Bleeding or clotting abnormalities
        2. Unstable angina
        3. Severe respiratory disease
        4. Known reaction to analgesics, anesthetics, etc.

Medical records must confirm the need for the dental services above.

Procedures that are payable in the circumstances explained above include:

1. Alveoplasty
2. Diagnostic X-rays
3. Multiple extractions or removal of unerupted teeth

c. **Other Dental Services**

Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:

1. Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
2. Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
3. Diagnostic X-rays
4. Physical therapy
5. Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

The Plan does not pay for:

a. Routine dental services

b. Treatment that was previously paid as a result of an accident

c. Dental implants and related services, including repair and maintenance of implants and surrounding tissue

d. Dental conditions existing before an accident requiring emergency dental treatment
e. Services to treat temporomandibular joint dysfunction (except as described above.)

Diagnostic Services

Locations: The Plan pays for diagnostic services subject to the conditions described below, in:

a. A participating hospital
   A participating ambulatory surgery facility
b. A participating skilled nursing facility
c. An office

The Plan pays for:

Diagnostic Testing
The Plan pays for the tests a physician uses to diagnose disease, illness, pregnancy or injury.

a. Physician services are payable for tests such as:
   1. Thyroid function
   2. Electrocardiogram (EKG)
   3. Electroencephalogram (EEG)
   4. Pulmonary function studies

b. Physician and independent physical therapist services are payable for the following tests:
   1. Electromyogram (EMG)
   2. Nerve conduction

   The test must be prescribed by a physician if performed by an independent physical therapist.

The Plan pays for the lab and pathology tests a physician uses to diagnose disease, illness pregnancy or injury. Services must be provided:

a. In a participating hospital (under the direction of a pathologist employed by the hospital) or
b. By your in-network physician, or
c. By another physician, if your in-network physician refers you to one, or
d. By an in-network lab at your in-network physician's direction.

   1. The Plan pays for standard office lab tests in your in-network physician's office. Other lab tests must be sent to an in-network laboratory.
   2. You will need to pay the out-of-network cost-share if tests are done by an out-of-network lab or in an out-of-network hospital.

Dialysis Services

Important: BCBSM shares the cost of treating End Stage Renal Disease (ESRD) with Medicare. It is important that you apply for Medicare coverage if you have ESRD. This is done through the Social Security Administration.

Locations: The Plan pays for dialysis services subject to the conditions below, in:

a. A participating hospital
b. An participating freestanding ESRD facility
c. A member's home

The Plan pays for:
Dialysis services (including physician services), supplies and equipment to treat:

a. Acute renal (kidney) failure
b. Chronic, irreversible kidney failure (End Stage Renal Disease (ESRD))

End Stage Renal Disease
The Plan pays for treatment of ESRD until the patient becomes eligible for Medicare. This period is a maximum of three months from when you apply for Medicare. Afterward BCBSM shares the cost of treatment with Medicare.

Services Provided in a Freestanding ESRD Facility

The Plan pays for:
a. Use of the freestanding end stage renal disease facility
b. Ultrafiltration
c. Equipment
d. Solutions
e. Routine laboratory tests
f. Drugs
g. Supplies
h. Other medically necessary services related to dialysis treatment

The Plan does not pay for:
a. Services provided by a nonparticipating end stage renal disease facility.
b. Services not provided by the employees of the ESRD facility.
c. Services not related to the dialysis process.

Services Provided in the Home
Dialysis services (hemodialysis and peritoneal dialysis) must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:

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

The Plan pays for:
a. Home hemodialysis
    1. Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
    2. Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guideline

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

The Plan does not pay for:

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

Durable Medical Equipment

Locations: The Plan pays for durable medical equipment in the following locations subject to the conditions described below:

a. A participating hospital
b. Participating skilled nursing facility
c. An office
d. A member's home

The Plan pays for:

a. Use of durable medical equipment while you are in the hospital.
b. The rental or purchase of durable medical equipment, if prescribed by a physician or other provider licensed to prescribe it. You may obtain it from:
    1. A participating hospital (when you are discharged)
    2. A DME supplier

c. In many instances the Plan covers the same items covered by Medicare Part B as of the date of purchase or rental. In some instances, however, BCBSM guidelines may differ from Medicare. Please call the BCBSM Customer Service center for specific coverage information.

DME items must meet the following guidelines:

a. The prescription includes a description of the equipment and the reason for the need or the diagnosis.
b. The physician or other provider licensed to prescribe it writes a new prescription when the current prescription expires; otherwise, the Plan will stop payment on the current expiration date, or 30 days after the date of the patient's death, whichever is earlier.

If the equipment is:

1. Rented, the Plan will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
2. Bought, the Plan will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

Continuous Positive Airway Pressure (CPAP)
When prescribed by a physician or provider licensed to prescribe it, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

a. The Plan will cover the rental fee only for the CPAP device. The Plans total rental payments will not exceed the plans approved amount to purchase the device. Once the plans rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device.
b. The Plan will pay for the rental or purchase of a humidifier for the CPAP device, if needed.
c. The Plan will pay for the purchase of any related supplies and accessories.
d. After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier or your physician must document your compliance.
    1. If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment.
    2. If you fail to comply with treatment requirements, The Plan will also no longer cover the purchase of supplies and accessories.

The Plan does not pay for:
a. Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
b. Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that patients can operate the equipment themselves
c. Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
d. Physician's equipment, such as stethoscopes
e. Self-help devices not primarily medical in nature, such as sauna baths and elevators
f. Experimental equipment

Emergency Treatment

Locations: The Plan pays for services to treat medical emergencies and accidental injuries in:
a. A hospital
b. An urgent care center
c. Other approved outpatient locations

The Plan pays for:
a. Facility and professional services to examine and treat a medical emergency or accidental injury.

Gender Dysphoria Treatment

The Plan pays for:
Medically necessary services for the treatment of gender dysphoria. This includes professional and facility services.

The Plan does not pay for:

a. Gender reassignment services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational.
b. See (Definitions) for an explanation of "gender dysphoria," "medically necessary," and "experimental treatment."

Home Health Care Services

Locations: The Plan pays for care and services provided in the patient's home.

Home health care provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home. Home health care must be:

a. Prescribed by the attending physician
b. Provided and billed by a **participating** home health care agency
c. Medically necessary
d. The following criteria for home health care must be met:
    1. The attending physician certifies that the patient is confined to the home because of illness.
    2. This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be difficult due to the nature or degree of the illness.
    3. The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.
    4. The agency accepts the patient into its program.

The Plan pays for:
Services provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill BCBSM for the services. They are:

a. Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
b. Social services by a licensed social worker, if requested by the patient's attending physician
c. The following when provided for rehabilitation:
    1. Physical therapy
    2. Occupational therapy
    3. Speech and language pathology services

    If services in a member's home are billed by a home health care agency, then these services will **not** count toward the visit maximums.

d. If physical, occupational or speech therapy cannot be done in the home, The Plan will pay for outpatient therapy. It may be in an outpatient department of a hospital or a physical therapy facility. Benefits are subject to the 60-visit maximums. If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximum
e. Part-time health aide services, including preparing meals, laundering, bathing and feeding if:
    1. The patient is receiving skilled nursing care or physical or speech therapy
    2. The patient's family cannot provide the services and the home health care agency has identified a need for these services for the patient to participate in the program
    3. The services are provided by a home health aide and supervised by a registered nurse employed by the agency

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

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

The Plan does not pay for:

a. General housekeeping services
b. Transportation to and from a hospital or other facility
c. Private duty nursing
d. Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
e. Durable medical equipment
f. Physician services (when billed by the home health care agency)
g. Custodial or nonskilled care
h. Services performed by a nonparticipating home health care provider

Hospice Care Services

Locations: The Plan pays for hospice care services in:

a. A participating hospice facility
b. A participating hospital
c. A participating skilled nursing facility
d. A member's home

The Plan pays for services to care for the terminally ill. Services must be provided through a participating hospice program. Hospice care services are payable for four 90-day periods. To be payable, the following criteria must be met:

a. The member or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
b. The following certifications are submitted to BCBSM:

1. For the first 90 days of hospice care coverage: A written certification stating that the patient is terminally ill, signed by the:

   A. Medical director of the hospice program or
   B. Physician of the hospice interdisciplinary group and
   C. Attending physician, if the patient has one

2. For the second 90-day period (submitted no later than two days after this 90-day period begins). The hospice must submit a second written certification of terminal illness signed by the:
   A. Medical director of the hospice or
   B. Physician of the hospice interdisciplinary group

3. For the third 90-day period (submitted no later than two days after this 90-day period begins). The hospice must submit a third written certification of terminal illness signed by the:
   A. Medical director of the hospice or

B. Physician of the hospice interdisciplinary group

4. For the fourth 90-day period (submitted no later than two days after this 90-day period begins). The hospice must submit a fourth written certification of terminal illness signed by the:
   A. Medical director of the hospice or
   B. Physician of the hospice interdisciplinary group

c. The patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that hospice care has been fully explained to them. The waiver explains that BCBSM does not pay for treatment of the terminal illness itself or related conditions during hospice care. BCBSM benefits for conditions not related to the terminal illness remain in effect.

The Plan pays for:
Counseling, evaluation, education and support services for the patient and his or her family from the hospice staff before the patient elects to use hospice services. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services, regular BCBSM coverage for services in connection with the terminal illness and related conditions are replaced by the following:

a. **Home Care Services**
1. Up to eight hours of routine home care per day
2. Continuous home care for up to 24 hours per day during periods of crisis
3. Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.

b. **Facility Services**

1. Inpatient care provided by:

   A. A participating hospice inpatient unit
   B. A participating hospital contracting with the hospice program or
   C. A skilled nursing facility contracting with the hospice program

2. Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)

3. Five days of occasional respite care during a 30-day period

c. **Hospice Services**
1. Physician services by a member of the hospice interdisciplinary team
2. Nursing care provided by, or under the supervision of, a registered nurse
3. Medical social services by a licensed social worker, provided under the direction of a physician
4. Counseling services to the patient and to caregivers, when care is provided at home
5. BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)

6. BCBSM-approved durable medical equipment furnished by the hospice program for use in the patient's home
7. Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
8. Bereavement counseling for the family after the patient's death

Hospice services are limited to a maximum amount. That amount is reviewed and adjusted from time to time. Once you reach the maximum, hospice benefits will still be covered under the case management program. Please call us for information about the current maximum amount.

d. **Professional Services**

1. Provided by the attending physician to make the member comfortable and to manage the terminal illness and related conditions
2. The Plan does not pay for physician services from a member of the hospice interdisciplinary team.
3. Professional services for hospice care are limited to a maximum amount. This amount is determined by BCBSM and reviewed at times. Once you reach the maximum, professional services will still be covered under the case management program. Please call BCBSM for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services described above.

How to Cancel Hospice Care Services

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

How to Reinstate Hospice Care Services

Hospice care services may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

The Plan does not pay for services:

a. Other than those furnished by the hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the patient's terminal illness.)
b. Of a hospice program other than the one designated by the patient. (If the designated program arranges for the patient to receive the services of another hospice program, the services are covered.)
c. That are not part of the plan of care established by the hospice program for the patient

Hospital Services

The services in this section are in addition to all other services listed in this SPD that are payable in a participating hospital. An example would be surgery.

Locations: The following services are payable in:

a. A participating hospital

The Plan pays for:

a. **Inpatient hospital services:**

1. Medical care by hospital personnel while you are receiving inpatient services.
2. Semiprivate room
3. Nursing services
4. Meals, including special diets
5. Services provided in a special care unit, such as intensive care
6. Oxygen and other therapeutic gases and their administration
7. Inhalation therapy
8. Electroconvulsive Treatment (ECT)
9. Pulmonary function evaluation
10. Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
11. Hyperbaric oxygenation (therapy given in a pressure chamber)

b. **Outpatient hospital services:**

If a service is payable as an inpatient service, it is also payable as an outpatient service. (Exceptions are services related to inpatient room, board, and inhalation therapy).

c. **Temporary Benefits for Hospital Services:**

If you are receiving services from a hospital that cancels its contract with BCBSM, you still have benefits. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to **six months** from the date the hospital ends its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM.

Infusion Therapy

BCBSM considers services from a participating infusion provider to be in-network. You will need to pay in-network cost-sharing for these services. What you pay may vary depending on the location you receive these services.

BCBSM may require approval for these services. Your in-network provider is responsible for obtaining approval.

Locations: The Plan pays for infusion therapy services:

a. A participating ambulatory infusion center
b. A member's home
c. An office
d. A participating hospital

To be eligible for infusion therapy services, your condition must be such that infusion therapy is:

a. Prescribed by a physician to manage an incurable or chronic condition or to treat a condition that requires acute care. For home infusion therapy, the condition must be able to be safely managed in the home
b. Medically necessary

c. Given by a participating infusion therapy provider

The Plan pays for:

a. Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy see the prior authorization for Specialty Pharmaceuticals requirement described in the Prescription Drug section.
b. Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care
c. Nursing services must meet the Plans guidelines to be covered.
d. Durable medical equipment, medical supplies and solutions needed for infusion therapy
e. Except for chemotherapeutic drugs, services provided for infusion therapy under the home health care benefit are not covered separately as elsewhere in this document.

The Plan does not pay for services rendered by **nonparticipating** infusion therapy providers.

Long-Term Acute Care Hospital Services

Locations: The Plan pays for services provided in a long-term acute care hospital (LTACH) subject to the conditions described below.

The Plan pays for:

The same services in an LTACH that the Plan would pay for in a participating hospital. The services are payable only if the following conditions are met. The long-term acute care hospital must:

a. Be located in Michigan
b. Participate with BCBSM, except under extenuating circumstances as determined by BCBSM
c. The provider must request and receive preapproval for inpatient services

LTACH is liable for the care if the inpatient services are not preapproved.

The Plan does not pay for:

a. Services in a nonparticipating long-term acute care hospital, including emergency services, unless BCBSM determines there are extenuating circumstances
b. Inpatient admissions that BCBSM has not preapproved
c. LTACH services if the patient's primary diagnosis is a mental health or substance use disorder condition

Maternity Care

Locations: The Plan pays for facility and professional services in:

a. A participating inpatient hospital setting
b. A participating birthing center
c. An office

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than:

a. 48 hours following a vaginal delivery
b. 96 hours following a delivery by cesarean section

However, The Plan may pay for a shorter stay if the attending physician or midwife discharges the mother earlier, after consulting the mother.

Federal law requires that the Plan cover the same benefits with the same cost-sharing levels during the 48 or 96 hours.

In addition, The Plan may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs. For information on preapproval, contact your BCBSM customer service representative.

The Plan pays for:

a. **Obstetrics**

Covered services provided by a physician or certified nurse midwife attending the delivery. These covered services include but are not limited to:

1. Pre-natal care, including maternity education provided in a physician's office as part of a pre-natal visit
2. Vaginal delivery or cesarean section when provided in:
   A. An participating hospital setting
   A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
3. Post-natal care, including a Papanicolau (PAP) smear during the six-week visit

a. Other services:

Covered services provided to the mother's newborn only during the 48 or 96 hours when the newborn has not been added to a BCBSM contract. These services include:

1. Newborn examination given by a physician other than the anesthesiologist or the mother's attending physician.
2. Routine care during the newborn's eligible hospital stay
3. Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities.

The Plan does not pays for:

b. Lamaze, parenting or other similar classes
c. Services provided to the newborn if one of the following apply:
   1. The newborn's mother is not covered under this certificate on the newborn's date of birth
   2. The newborn is covered under a BCBSM or other health care benefit plan on his or her date of birth
   3. The subscriber directs BCBSM not to cover the newborn's services
d. Services provided to the newborn occur after the 48 or 96 hours

Medical Supplies

Locations: The Plan pays for medical supplies in:

a. A participating hospital
b. A participating hospice
c. A participating outpatient facility
d. A participating skilled nursing facility
e. An office
f. A member's home

The Plan pays for: Medical supplies and dressings used for the treatment of a specific medical condition. The quantity of medical supplies and dressings must be medically necessary. They include but are not limited to:

a. Gauze, cotton, fabrics, plaster and other materials used in dressings and casts
b. Ostomy sets and accessories
c. Catheterization equipment and urinary sets

Mental Health Services

Locations: The Plan pays for mental health services subject to the conditions described below, in:

a. A participating hospital
b. An participating psychiatric residential treatment facility (PRTF)
c. A participating outpatient psychiatric care (OPC) facility.
d. An office

Mental health services that are the equivalent of an office visit are covered as an office visit..

BCBSM covers medically necessary and medically appropriate services to evaluate, diagnose, and treat mental health conditions that are in accordance with generally accepted standards of practice.

Medically necessary covered services are those considered by a professional provider, exercising prudent clinical judgment, as clinically appropriate, and are considered effective for the member's illness, injury, or disease. The services must not be more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results.

For diagnostic testing, the results must be essential to, and used in the diagnosis or management of, the patient's condition.

BCBSM does not cover treatment or services that:

1. Have not been determined as medically necessary or appropriate
2. Are mainly for the convenience of the member or health care provider
3. Are considered experimental or investigational

When you receive mental health or substance use disorder services under a case management agreement that you, your provider and a BCBSM case manager have signed, you will pay your in-network cost-share even if the provider is out-of-network and/or does not participate with BCBSM.

The Plan pays for:

a. Electroconvulsive therapy (ECT) is covered only in an inpatient or outpatient hospital location
    1. ECT when administered by, or under the supervision of a physician
    2. Anesthetics for ECT when administered by, or under the supervision of, a physician other than the physician giving the ECT

b. **Inpatient hospital-mental health services**

    The following inpatient mental health services are payable when provided by a physician or by a fully licensed psychologist who has hospital privileges:

1. Individual psychotherapeutic treatment
2. Family counseling for members of a patient's family
3. Group psychotherapeutic treatment
4. Psychological testing prescribed or performed by a physician. The tests must be directly related to the condition for which the patient is admitted or have a full role in rehabilitative or psychiatric treatment programs
5. Inpatient consultations. If a physician needs help diagnosing or treating a patient's condition, the Plan pays for inpatient consultations. They must be provided by a physician or fully licensed psychologist who has the skills or knowledge needed for the case.

The Plan does not pay for:

1. Consultations required by a facility's or program's rules
2. Marital counseling
3. Services provided by a nonparticipating hospital

c. **Psychiatric residential treatment**

Psychiatric residential treatment is covered only after it has been preapproved by BCBSM or its representative. Covered services must be provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

The Plan pays for:

1. Services provided by facility staff
2. Individual psychotherapeutic treatment
3. Family counseling for members of a patient's family
4. Group psychotherapeutic treatment
5. Prescribed drugs given by the facility

The Plan does not pay for:

1. Consultations required by a facility's or program's rules
2. Marital counseling
3. Services provided by a facility located in Michigan that does not participate with BCBSM or by a facility located outside of Michigan that does not participate with its local Blue Cross/Blue Shield plan
4. An admission to a psychiatric residential treatment facility or services by the facility that are not preapproved before they occur. BCBSM or its representative must issue the preapproval.

   If preapproval is not obtained:

   A participating or in-network facility that provided the care cannot bill the member for the cost of the admission or services.

   A nonparticipating or out-of-network facility that provided the care may require the member to pay for the admission and services.

5. Services that are not focused on improving the member's functioning
6. Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program
7. A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community

8. A residential program that serves to protect family members and other individuals in the member's living environment
9. Services or treatment that are cognitive in nature or supplies related to such services or treatment
10. Court-ordered services
11. Treatment or supplies that do not meet BCBSM requirements
12. Transitional living centers such as half-way and three-quarter way houses
13. Therapeutic boarding schools
14. Milieu therapies, such as wilderness program, supportive houses or group homes
15. Domiciliary foster care
16. Custodial care
17. Treatment or programs for sex offenders or perpetrators of sexual or physical violence
18. Services to hold or confine a member under chemical influence when the member does not require medical treatment
19. A private room or an apartment
20. Services provided by a nonparticipating psychiatric residential treatment facility
21. Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

d. **Psychiatric partial hospitalization (PHP) treatment program**

Psychiatric partial hospitalizations are covered only in hospitals and outpatient psychiatric care facilities that participate with BCBSM and have a PHP program

The Plan pays for:

1. Services provided by the hospital's or facility's staff
2. Ancillary services
3. Prescribed drugs given by the hospital or facility during the patient's treatment
4. Individual psychotherapeutic treatment
5. Group psychotherapeutic treatment
6. Psychological testing
   The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.
7. Family counseling for members of patient's family

e. **Outpatient Psychiatric Care Facility and Office Setting for Mental Health Services**

The Plan only pays for services in a participating outpatient psychiatric care facility and office setting for mental health services.

The Plan pays for:

1. Services provided by the facility's staff

2. Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider, as determined by BCBSM in an office setting or a participating outpatient psychiatric care facility:

1. Individual psychotherapeutic treatment
2. Family counseling for members of a patient's family
3. Group psychotherapeutic treatment
4. Psychological testing. The tests must be directly related to the condition for which the patient is admitted or has a full role in rehabilitative or psychiatric treatment programs.
5. Prescribed drugs given by the facility in connection with treatment
6. A partial hospitalization program as described in the PHP section of this document

The Plan does not pay for:

1. Services provided in a skilled nursing facility or through a residential substance abuse treatment program
2. Marital counseling
3. Consultations required by a facility or program's rules
4. Services provided by a nonparticipating outpatient psychiatric care facility

Autism Spectrum Disorders

Covered Autism Spectrum Disorders

The Plan pays 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.

Covered Services

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.

Before applied behavior analysis services will be covered, a BCBSM approved autism evaluation center must evaluate and diagnose the member as having one of the covered autism spectrum disorders.

Treatment 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:

a. Applied behavior analysis treatment. It must be provided or supervised by a board certified behavior analyst or licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

   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.

   1. Applied behavior analysis treatment is covered subject to the following requirements:

      A. Treatment Plan – Applied behavior analysis treatment must be included in a treatment plan recommended by a BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition. If requested by BCBSM, the cost of treatment review will be paid by BCBSM.

      B. Prior Authorization – Applied behavior analysis treatment must be approved for payment through BCBSM's prior authorization process. If prior authorization is not obtained, rendered services will not be covered and the member will be

responsible to pay for those services. Prior authorization is not required for any other covered autism services.

2. 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.
3. Psychiatric care. It includes evidence-based direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.
4. Psychological care. It includes evidence-based direct or consultative services provided by a psychologist licensed in the state where he/she practices.
   Benefits for autism disorders are in addition to any psychiatric, psychological and non-applied behavior analysis benefits that may be available under this Plan.
5. 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:

a. Medically necessary and appropriate

b. Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder.

c. Deemed safe and effective by BCBSM.
   Services or treatments that are deemed experimental or investigational by BCBSM, such as applied behavior analysis treatment, are covered only when they are approved by BCBSM and included in a treatment plan recommended by the BCBSM-approved autism evaluation center that evaluated and diagnosed the member's condition.

Limitations and Exclusions

In addition to those listed in this Plan, the following limitations and exclusions apply:

a. Benefits for applied behavior analysis treatment are limited to children through the age of 18. This age limitation does not apply to psychiatric, psychological, non-applied behavior analysis services and services to diagnose autism.
b. 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 and coinsurance imposed under this Plan.
c. 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.
d. Conditions such as Rett's Disorder and Childhood Disintegrative Disorder are not payable under this Plan.
e. 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:
   1. Experimental treatment
   2. Treatment of chronic, developmental or congenital conditions

3. Treatment of learning disabilities or inherited speech abnormalities
4. 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.

f. All autism services performed in Michigan must be provided by providers who are registered with BCBSM as a participating or nonparticipating provider.
    a. All autism services performed outside of Michigan must be provided by providers that participate with their local Blue Cross/Blue Shield plan.

Newborn Care

If the newborn is not covered under this BCBSM contract, he/she may qualify for coverage under the mother's maternity care benefit.

Locations: The Plan pays for facility and professional services for routine newborn nursery care during an eligible hospital stay in.

a. A participating hospital setting
b. A participating birthing center

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for a newborn child to less than:

a. 48 hours following a vaginal delivery
b. 96 hours following a delivery by cesarean section

However, The Plan may pay for a shorter stay if the attending physician or midwife discharges the newborn earlier, after consulting the mother.

Federal law requires that the Plan cover the same benefits with the same cost-sharing levels during the 48 or 96 hours.

In addition, The Plan may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs. For information on preapproval, contact your BCBSM customer service representative.

The Plan pays for:

a. Newborn Examination. The exam must be given by a physician other than the anesthesiologist or the mother's attending physicians.
b. Routine care during an eligible inpatient hospital stay.

The Plan does not pay for:

a. Parenting or other similar classes

Occupational Therapy

Locations: The Plan pays for facility and professional occupational therapy services in the following locations subject to the conditions described below:

a. A participating hospital. Inpatient therapy must be used to treat the condition for which the member is hospitalized.
b. A participating freestanding outpatient physical therapy facility
c. An office
d. A participating skilled nursing facility
e. A member's home
f. A nursing home, if it is the member's primary residence

The Plan pays for:

a. A maximum of 60 outpatient visits per member per year.

Important: See Note below about treatment dates and initial evaluations. This 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:

1. Occupational therapy
2. Physical therapy (includes physical therapy by a chiropractor)
3. Speech and language pathology
4. Chiropractic mechanical traction

If services in a member's home are billed by a professional provider, an independent physical therapist or occupational therapist, they will count toward the visit maximums. If services in a member's home are billed by a home health care agency, they will not count toward the visit maximums.

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

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

Occupational therapy must be:

a. For inpatient services, prescribed by a professional provider licensed to prescribe occupational therapy services
b. Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning

Given by:

a. A physician (M.D. or D.O.) in an outpatient setting
b. An occupational therapist
c. An occupational therapy assistant under the indirect supervision of an occupational therapist, who cosigns all assessments and patients' progress notes. Both the occupational therapist and the

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

d. An athletic trainer under the direct supervision of an occupational therapist in an outpatient setting

The Plan does not pay for:

a. More than 60 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.
b. Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without an occupational therapy treatment plan that guides and helps to monitor the provided therapy.
c. Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
d. Services received from a nonparticipating hospital or freestanding outpatient physical therapy facility
e. Services received from an independent sports medicine clinic
f. Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

   The Plan may pay for treatment to improve cognition if it is:

   1. Part of a comprehensive rehabilitation plan
   2. Medically necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM

g. Recreational therapy
h. Patient education and home programs

Office, Outpatient and Home Medical Care Visits

Locations: The Plan pays for the following when provided by a physician or eligible professional provider when medically necessary:

Office visits. They include:

a. Urgent care visits
b. Office consultations
c. Online visits
d. Retail health clinic visits
e. Outpatient visits
f. Home medical care visits

The following are examples of services that will not require any copayments when provided in an in-network physician's office:

1. Prenatal and postnatal care
2. Allergy testing and therapy
3. Therapeutic injections
4. Pre-surgical consultations

The Plan does not pay for routine eye exams and hearing tests, unless they are related to an illness, injury or pregnancy.

Mental Health and Substance Use Disorder Treatment
Some mental health and substance use disorder services are considered by BCBSM to be the same as an office visit. When a mental health or substance use disorder service is considered by BCBSM to be the same as an office visit, The Plan will consider the claim an office visit.

Online Visits

The Plan pays for:
a. The diagnosis of a condition
b. Treatment and consultation recommendations

The online visit must allow the patient to interact with the professional provider in real time. Treatment and consultation recommendations made online, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

Online visits must meet BCBSM's standards for an Evaluation and Management visit.

The online visit provider must be licensed in the state where the patient is located during the online visit.

Online visits do not include:
a. Treatment of substance use disorders
b. Reporting of normal test results
c. Provision of educational materials
d. Handling of administrative issues, such as registration, scheduling of appointments, or updating billing information

Oncology Clinical Trials

Locations: The Plan pays for services performed in a designated cancer center subject to the conditions described below.

Benefits for specified oncology clinical trials provide coverage for:
a. Preapproved, specified bone marrow and peripheral blood stem cell transplants and their related services
b. FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer
c. All stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial

Benefits are not limited or precluded for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Mandatory Preapproval
All services, admissions or lengths of stay for the services below must be preapproved by BCBSM.
Preapproval ensures that you and your physician know ahead of time that services are covered. If preapproval is not obtained, services will not be covered. This includes:
1. Hospital admission
2. Length of stay
3. All payable medical care and treatment services.

The decision to preapprove hospital and medical services is based on the information your physician submits to the Plan. BCBSM reserves the right to request more information if needed.

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, admissions and length of stay not being covered.

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.

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

Preapproval will be granted if:

a. The patient is an eligible BCBSM member.
b. The patient has BCBSM hospital-medical-surgical coverage.
c. The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
d. The proposed services are medically necessary.
e. An inpatient stay at a cancer center if it is medically necessary (in those cases requiring inpatient treatment). BCBSM must preapprove the admission before it occurs.
f. The length of stay at a designated cancer center is medically necessary. BCBSM must preapprove the length of stay before it begins.

The Plan pays for:

a. **Antineoplastic drugs** If Michigan law requires it, the Plan covers these drugs and the reasonable cost of giving them.
b. **Immunizations** The Plan pays for vaccines against infection during the first 24 months after a transplant as recommended by the ACIP (Advisory Committee on Immunization Practices).
c. **Autologous Transplants**
    1. Infusion of colony stimulating growth factors
    2. Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
    3. Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
    4. High-dose chemotherapy and/or total body irradiation
    5. Infusion of bone marrow and/or peripheral blood stem cells
    6. Hospitalization

d. **Allogeneic Transplants**
    1. Blood tests to evaluate donors (if not covered by the potential donor's insurance)

2. 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.
3. Infusion of colony stimulating growth factors
4. Harvesting and storage (both covered even if it is not covered by the donor's insurance) of the donor's:
5. Bone marrow
6. Peripheral blood stem cell (including peripheral blood stem cell pheresis)
7. Umbilical cord blood
8. The recipient of harvested material must be a BCBSM member.
9. High-dose chemotherapy and/or total body irradiation
10. Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
11. T cell depleted infusion
12. Donor lymphocyte infusion
13. Hospitalization

e. **Travel and Lodging**

The Plan will pay up to a total of $5,000 for your travel and lodging expenses. They must be 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.

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

1. $60 per day for travel
2. $50 per day for lodging

These daily allowances may be adjusted from time to time. Please call BCBSM to find out the current maximums.

The Plan does not pay for:

a. An admission to a designated center or a length of stay at a designated center that has not been preapproved
b. Services that have not been preapproved
c. Services rendered at a non-designated cancer center
d. Services that are not medically necessary
e. Services provided by persons or entities that are not legally qualified or licensed to provide such services
f. Donor services for a transplant recipient who is not a BCBSM member
g. Services rendered to a donor when the donor's health care coverage will pay for such services
h. 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
i. More than two single transplants per member for the same condition
j. Non-health care related services and/or research management (such as administrative costs)
k. Transplants performed at a center that is not a designated cancer center or its affiliate

l. Search of an international donor registry
m. Experimental treatment not included in this Plan
n. Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
o. Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:

Alcoholic beverages	Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services	Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)	Mortgage or rent payments	Tips
Car maintenance	Furniture rental	Kennel fees	Reimbursement of food stamps	
Clothing, toiletries	Household products	Lost wages	Security deposits, cash advances	
Dry cleaning or laundry services	Household utilities (including cellular telephones)	Maids, babysitters or day care services	Services provided by family members	

p. Any other services, admissions or length of stay related to any of the above exclusions
q. The limitations and exclusions listed elsewhere in this document, also apply to this benefit.

Optometrist Services

The Plan pays for:

Services performed by a licensed optometrist within the scope of his or her license and subject to the conditions described below.

a. The optometrist must provide the covered services within the state of Michigan.
b. The optometrist must be:
    1. Licensed in the state of Michigan
    2. Certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents

If you get services from an optometrist who does not participate in BCBSM's vision program, they will be treated as services of a nonparticipating provider.

Outpatient Diabetes Management Program

All cost-sharing for diabetes self-management training is waived when performed by an in-network provider.

Locations: The Plan pays for services provided in a home or (for training) in a group setting subject to the conditions described below.

The Plan pays for:

a. Selected services and medical supplies to treat and control diabetes when:
b. Determined to be medically necessary
c. Prescribed by an M.D. or D.O.

Diabetes services and medical supplies include:

a. Blood glucose monitors
b. Blood glucose monitors for the legally blind
c. Insulin pumps
d. Test strips for glucose monitors
e. Visual reading and urine test strips
f. Lancets
g. Spring-powered lancet devices
h. Syringes
i. Insulin
j. Medical supplies required for the use of an insulin pump
k. Nonexperimental drugs to control blood sugar
l. Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
m. Diabetes self-management training conducted in a group setting, whenever practicable, if:
    1. Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
    2. Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
    3. The provider of self-management training must be:
        A. Certified to receive Medicare or Medicaid reimbursement or
        B. Certified by the Michigan Department of Community Health.

You pay no cost-sharing for training from an in-network provider.

Pain Management

Locations: The Plan pays for services to manage pain, subject to the conditions described below, in:

a. A participating hospital
b. A participating outpatient facility
c. An office

The Plan pays for:

a. Covered services and devices for pain management when medically necessary as documented by a physician.
b. Covered services performed by a certified registered nurse anesthetist.

The Plan does not pay for:

Services and devices for pain management provided by a nonparticipating hospital or facility.

Physical Therapy

Locations: The Plan pays for physical therapy services in:

a. outpatient participating hospital. Inpatient therapy must be used to treat the condition for which the member is hospitalized.
b. A participating skilled nursing facility

c. A participating freestanding outpatient physical therapy facility. For freestanding facilities, the Plan pays the facility directly for the service, not the individual provider who rendered the service.
d. An office
e. The member's home
f. A nursing home, if it is the member's primary residence

The Plan pays for:

a. A maximum of 60 outpatient visits per member per year.

Important: See Note below about treatment dates and initial evaluations. This 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:

1. Occupational therapy
2. Physical therapy (includes physical therapy by a chiropractor)
3. Speech Therapy
4. Chiropractic mechanical traction

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

An initial evaluation is <u>not</u> counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit (described above)

Physical therapy must be:
a. Prescribed by a professional provider licensed to prescribe it, unless it is performed by a chiropractor.
b. Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning
c. Given by the approved providers in the locations listed below:

Locations	Providers
• A hospital, inpatient or outpatient • A skilled nursing facility • A freestanding outpatient physical therapy facility • A provider's office • A member's home • A nursing home if it is the member's primary residence	• A doctor (M.D., D.O. or a podiatrist) • A dentist or optometrist • A chiropractor • A physical therapist, physical therapist assistant, or athletic trainer • A physician's assistant • A certified nurse practitioner

Not all of the providers listed above can perform physical therapy in all of these locations. And some of these providers must be supervised by other types of providers for their services to be covered. Please call BCBSM Customer Service if you have questions about where physical therapy can be provided or who can provide it.

The Plan does not pay for:

a. More than 60 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.

b. Services received from a nonparticipating hospital, freestanding outpatient physical therapy facility, skilled nursing facility, or any other facility independent of a hospital

c. Services received from an independent sports medicine clinic

d. Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program

e. Therapy to treat long-standing chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a physical therapy treatment plan that guides and helps to monitor the provided therapy.

f. Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program

g. Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a physical therapy treatment plan that guides and helps to monitor the provided therapy

   The Plan may pay for treatment to improve cognition if it is:

   1. Part of a comprehensive rehabilitation plan, and
   2. Medically necessary to treat severe deficits in patients who have certain conditions that are identified by BCBSM

h. Patient education and home programs (such as home exercise programs)

i. Sports medicine for purposes such as prevention of injuries or for conditioning

j. Recreational therapy

Prescription Drugs

Prescription drugs obtained from a pharmacy are not payable under this Plan.

Locations: The Plan pays for medically necessary prescription drugs. They can be given in a participating hospital or in other approved locations. Prescription drugs are subject to the conditions described below

The Plan pays for:

a. **Drugs Received in a Hospital (Inpatient or Outpatient)**

   1. The Plan pays for prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) administered as part of the treatment for the disease, condition or injury that are:
      i. Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act and
      ii. Used during an inpatient hospital stay or dispensed when part of covered outpatient services

b. **Drugs Received in Other Locations**

   Drugs are also payable:

   1. In a participating freestanding ambulatory surgery facility when directly related to surgery
   2. In a participating freestanding ESRD facility in conjunction with dialysis services
   3. In a participating skilled nursing facility
   4. As part of home health services when services are provided by a participating hospital
   5. When required for infusion therapy
   6. In a participating hospice for the comfort of the patient

7. In a participating residential substance abuse treatment facility or as part of a participating outpatient substance treatment program.

c. **Drugs Administered by a Physician**

1. **Injectable Drugs**

The Plan pays for FDA-approved, injectable drugs or biologicals, and their administration. The drugs must be:

a. FDA Approved,
b. Ordered or supplied by a physician, and
c. Administered by the physician or under the physician's supervision.

2. **Specialty Pharmaceuticals**

The Plan will pay for approved specialty drugs to be given to you by an in-network or participating provider.

The Plan pays for the:

a. Drug and their administration when it is ordered and billed by a physician, or
b. Drug when it is billed by the specialty pharmacy
c. Physician's administration of the drug

Self-injected drugs **are not** covered

d. **Hemophilia Medication**

1. The Plan will pay for hemophilia factor product when you get it from:
   A. In-network providers
   B. Out-of-network providers
   C. Participating providers
   D. Nonparticipating providers
2. The Plan will pay for supplies for the infusion of the hemophilia factor product. If you buy them from a participating provider, the Plan will pay the provider directly. If you buy them from a nonparticipating provider, the Plan will pay you and you will need to pay the nonparticipating provider.

e. **Prior Authorization for Specialty Pharmaceuticals**

Prior authorization is required for select specialty drugs to be administered in locations that have been determined by BCBSM. These locations include, but not limited to:

1. Office
2. Clinic
3. Home
4. Outpatient Facilities

BCBSM requires prior authorization for specialty drugs for in-state and out-of-state services. Your physician should contact BCBSM and follow BCBSM's utilization management processes to get prior authorization for your specialty drug. BCBSM will notify your physician if the request is approved. Only FDA-approved drugs are eligible to be preauthorized. Of those drugs, The Plan will preauthorize only the specialty drugs that meet the Plans medical policy standards for the treatment of your condition.

If your physician asks for prior authorization, but it is not approved by BCBSM, you have the right to appeal under applicable law. If the prior authorization is not approved through the appeal, you will be responsible for the full cost of the specialty drug.

If your physician does not get prior authorization, BCBSM will deny the claim and you will be responsible for the full cost of the specialty drug.

If your physician did not get prior authorization and you appeal the denial of the claim, BCBSM will review it to determine if the benefits can be paid. If BCBSM upholds the denial, you have the right to appeal under applicable law.

If Medicare is your primary payer, your physician does not have to get prior authorization.

f. **Request for Drugs Not on BCBSM's Drug List**

If your prescription drug coverage is limited to an approved drug list, BCBSM must approve coverage of a prescription drug not on the list *before* it is dispensed. If you or your provider do not obtain approval before the drug is dispensed, the drug will not be covered.

To request BCBSM's approval, you, your designee, or the prescribing provider or the provider's designee should contact BCBSM and follow BCBSM's exception request process.

For expedited requests due to exigent circumstances:
BCBSM will notify the person making the request of BCBSM's decision (either approval or denial) within 24 hours after BCBSM gets all of the information needed to make a determination.

For requests that are not due to exigent circumstances:
If your request is not an exigent circumstance, BCBSM will notify you of the decision within 72 hours after BCBSM gets all of the information needed to make a determination.

If BCBSM approves the exception request, you will have to pay your deductibles, coinsurances or copayments.

Only FDA-approved drugs are eligible for an exception. Of those drugs, BCBSM will only approve the drugs that meet BCBSM's clinical criteria and are effective in treating your condition.

To learn more about this process, visit www.bcbsm.com or call the Customer Service number on the back of your card.

Preventive Care Services

The Plan pays for all preventive and immunization services required under the Patient Protection and Affordable Care Act (PPACA). Because the services required under PPACA change from time-to-time, the Plan has mentioned only some of them in this document. To see a complete list, go to the https://www.healthcare.gov/preventive-care-benefits/children website. You may also contact BCBSM customer service.

Most preventive care services are covered only when performed by an in-network provider. But, colonoscopies, mammograms, and women's contraceptive services are covered whether they are done by

an in-network or an out-of-network provider. This section describes what the Plan covers for all preventive care services.

Locations: The Plan pays for facility and professional services for preventive care in the following locations subject to the conditions described below:

a. A participating hospital
b. A participating facility (e.g. an ambulatory surgery center)
c. A professional provider's office
d. The Plan will also pay an independent laboratory to analyze a test.

The Plan pays for:

The Plan pays for the following services only when supplied by in-network providers:

a. Preventive care services
b. Related reading and interpretation of your test results
   But, if an in-network provider does a covered preventive test, and an out-of-network provider reads and interprets the results, The Plan will pay the claim from the out-of-network provider as if it were an in-network claim. This means you will not have to pay your out-of-network cost-share.

Cost-sharing is not required for these services when performed by an in-network provider.

a. **Health Maintenance Examination**
   One exam per member, per calendar year; this is a full history and physical exam. It includes taking your blood pressure, looking for skin malignancies, a breast exam, a testicular exam, a rectal exam and health counseling about any potential risk factors you may encounter.

b. **Flexible Sigmoidoscopy Examination**
   One routine flexible sigmoidoscopy examination per member, per calendar year.

c. **Gynecological Examination**
   One routine gynecological examination per member, per calendar year.

d. **Routine Pap Smear**
   Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.

e. **Screening Mammography**
   The Plan pays for one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. You will not have to pay your cost-share if this service is done by an in-network provider. If the mammogram is done by an out-of-network provider, you will have to pay your out-of-network cost-share.
   The Plan will pay for an out-of-network provider to read and interpret your mammogram, but only when the mammogram itself was done by an in-network provider.

f. **Fecal Occult Blood Screening**
   One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.

g. **Well-Baby and Child Care Visits**

The Plan pays for well-baby and child care visits as follows:

1. Eight visits for children from birth through 12 months
2. Six visits for children 13 months through 23 months
3. Six visits for children 24 months through 35 months
4. Two visits for children 36 months through 47 months
5. Child care visits after 47 months are limited to one per member, per calendar year under your health maintenance exam benefit.

h. **Immunizations**

The Plan pays for childhood and adult immunizations. The Plan follows the recommendations of the Advisory Committee on Immunization Practices. The Plan may also follow other sources as known to BCBSM.

The Plan pays for all other immunizations and preventive care benefits ordered by PPACA at the time the services are performed.

i. **Prostate Specific Antigen Screening**

The Plan pays for one routine prostate specific antigen screening per member, per calendar year

j. **Routine Laboratory and Radiology Services**

The Plan pays for the following services once per member, per calendar year, when performed as routine screening:

1. Chemical profile
2. Complete blood count or any of its components
3. Urinalysis
4. Chest X-ray
5. EKG
6. Cholesterol testing

k. **Colonoscopy**

Hospital and physician benefits for colonoscopy services are payable at 100 percent of the BCBSM approved amount as follows:

1. The Plan pays for one routine screening colonoscopy once per member per calendar year. It can be done by an in-network or an out-of-network provider.
2. If you have an in-network provider do the screening, you will not have to pay your cost-share.
3. If you have an out-of-network provider do the screening, you will have to pay your out-of-network cost-share.
4. If you need another colonoscopy done in the same calendar year, you will have to pay your cost-share. It can be done by an in-network or out-of-network provider.

l. **Morbid Obesity Weight Management**

For a member with a BMI of 30 or above, the Plan pays for 26 visits per member per calendar year. Visits can include nutritional counseling, such as dietician services, billed by a physician or other provider recognized by BCBSM.

m. **Tobacco Cessation Programs**
The Plan will pay for screening, counseling and select prescription drugs to help you stop smoking.

n. **Women's Preventive Care Contraceptive Services**

1. Voluntary Sterilization for Females
   The Plan pays for hospital, facility, and physician's services for voluntary sterilizations for females.
2. Contraceptive Counseling
   The Plan pays for contraceptive counseling services provided to females during an annual physical or at a separate counseling session.
3. Contraceptive Devices
   The Plan will pay for a contraceptive device that needs a prescription by a physician, certified nurse midwife, or other legally authorized professional provider. The Plan will also pay the provider to put in and take out a device.
4. Contraceptive Injections
   The Plan pays for injections given by a physician, certified nurse midwife, or other eligible provider. The Plan also pays the provider for the injected medication if the provider supplies it. If a physician, certified nurse midwife, or other eligible provider injects you with a contraceptive medication you bought from a pharmacy, the Plan only pays the provider for the injection.
5. Genetic Testing
   The Plan pays for BRCA (counseling about genetic testing) – for women at higher risk

The Plan does not pay for:
Screening and preventive services that are:

a. Not listed in this document or
b. Not required to be covered under PPACA. To see a complete list of the services and immunizations that must be covered under PPACA go to the https://www.healthcare.gov/preventive-care-benefits/children website.
c. You may also contact BCBSM Customer Service.

Private Duty Nursing Services

Charges for private duty nursing services provided by a Home Health Care Agency in a private home (non-facility) setting will be considered if the care satisfies the Plan's Medically Necessary criteria as well as all of the following requirements:

a. The services are not permanent but temporary (short-term) and transitional in nature and may include training caregivers to provide the necessary services.
b. The services are for the purpose of restoring/maintaining the Covered Person's maximal level of function and health.
c. Services require a longer duration of skilled care than can be provided by a skilled nursing visit as described in the Home Health Care benefit.
d. The nursing care is required so frequently that the need for care is continuous whether delivered by a skilled professional or a trained caregiver.

e. The skilled care is provided by a nurse who is not related to or living with the patient. Skilled nursing services are those services that must be performed by a registered nurse or licensed practical nurse or require a nurse to train caregivers to perform.

f. The Covered Person is medically stable (for example, the Covered Person is clinically stable for discharge from the Hospital to the home) and all reasonably anticipated medical needs can be met in the home with temporary (short-term) private duty nursing support.

g. There is at least one identified caregiver for the Covered Person who will be trained to provide care to the Covered Person when the nurse is not on duty and after the temporary (short-term) private duty nursing care ends. If no family or caregivers are available to provide this care, any private duty nursing services provided will not be eligible for payment under this benefit. Where the Covered Person is not eligible for private duty nursing care under this benefit, alternative level of care placement, such as a skilled nursing facility or custodial nursing home, may be appropriate.

h. BCBS must certify the care and have proof of an established transitional treatment plan on file before private duty nursing services commence. As part of this certification process, the Plan may require (initially and periodically) a physician certification letter from the Covered Person's Physician with the following components:

    1. Diagnosis
    2. Treatment plan
    3. Specific duties
    4. Explanation of medical necessity
    5. Estimated length of time care is needed
    6. Hour-by-hour nursing notes must be attached to the letter (if determined to be necessary and requested by the Claim Administrator or the Utilization Review Department)

Private duty nursing care cannot be reviewed or processed for payment without an initial and periodic certification that the care is Medically Necessary.

Generally, 24-hour per day private duty nursing care will not be approved. The hours and duration of the initial approval for private duty nursing care will be determined by BCBS. Approval for continued private duty nursing care for the period determined by BCBS shall be contingent upon:

a. Updated medical orders from the prescribing Physician

b. Continued eligibility by meeting all of the initial criteria

c. Charges for the following are not covered under this benefit:

d. Maintenance care or custodial care for a Covered Person. In no event will such care be considered eligible under the Private Duty Nursing benefit.

e. Respite care for a caregiver.

f. Services to allow the Covered Person's family or caregiver to work or to leave the home for any other reason.

g. Private duty nursing services rendered in a facility setting, including, but not limited to, care provided to a patient in an acute Inpatient Hospital, Inpatient rehabilitation facility, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility.

h. Services provided in a school setting.

i. Services for senile deterioration or mental deficiency.

Professional Services

The services listed in this section are in addition to all of the other services listed in this document... The services in this section are also payable to a professional provider.

a. **Certified Nurse Practitioner Services:** The Plan pays for the covered services that are provided by a certified nurse practitioner.

Inpatient and Outpatient Consultations: If a physician needs help diagnosing or treating a patient's condition, The Plan pays for inpatient and outpatient consultations. They must be provided by a physician or professional provider who has the skills or knowledge needed for the case. The Plan does not pay for staff consultations required by a facility or program's rules.
When you have a consultation appointment in an in-network physician's office, you will need to pay your copayment.

c. Therapeutic Injections

Prosthetic and Orthotic Devices

Locations: The Plan pays for prosthetic and orthotic devices while you are in a participating hospital or for use outside of the hospital. The Plans payment is based on meeting the conditions described below.

The Plan pays for:

Prosthetic and orthotic devices:
a. Prescribed by a physician or certified nurse practitioner
b. And permanently implanted in the body
c. Or used externally, such as an artificial eye, leg, arm

The prescription must include a description of the equipment and the reason for the need or the diagnosis. Covered services include:

1. The cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features
2. Cost of purchasing or replacing the device
3. Cost of developing and fitting the basic device
4. Any medically necessary special features
5. Repairs, limited to the cost of a new device

The Plan will pay for the cost to replace a prosthetic device due to:
a. A change in the patient's condition
b. Damage to the device so that it cannot be restored
c. Loss of the device

Coverage Guidelines
BCBSM covers external prosthetic and orthotic devices that are payable by Medicare Part B. They are covered as of the date they were bought or rented. In some cases BCBSM guidelines may be different from

those of Medicare Part B. Please call your local BCBSM customer service center for specific coverage information.

To be covered, custom-made devices must be furnished:

a. By a fully accredited provider
b. With BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC).

You may call BCBSM to confirm a provider's status.

Prosthetic and orthotic suppliers may include:

a. M.D.s, D.O.s
b. Podiatrists
c. Prosthetists
d. Orthotists

All suppliers must meet BCBSM qualification standards.

Note: An optometrist who is also a prosthetist may only provide ocular prostheses.

Provider Limitations

If a provider is participating with BCBSM but is <u>not</u> accredited by ABC, only the following devices are covered:

a. External breast prostheses following a mastectomy which include:
    1. Two post-surgical brassieres and
    2. Two brassieres in any 12-month period thereafter

    Additional brassieres are covered if they are required:
    1. Because of significant change in body weight
    2. For hygienic reasons

b. Prefabricated custom-fitted orthotic devices
c. Artificial eyes, ears, noses and larynxes
d. Ostomy sets and accessories, catheterization equipment and urinary sets
e. Prescription eyeglasses or contacts lenses after cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Optometrists may provide these lenses
f. External cardiac pacemakers
g. Therapeutic shoes, shoe modifications and inserts for persons with diabetes
h. Maxillofacial prostheses that have been approved by BCBSM. Dentists may provide you with these devices.

If you have an urgent need for an item that is not custom-made (e.g., wrist braces, ankle braces, or shoulder immobilizers), The Plan will pay for the item to be provided by an M.D., D.O., or podiatrist. Please call your local BCBSM customer service center for information on which devices are covered.

The Plan does not pay for:

a. Hair prostheses such as wigs, hair pieces, hair implants, etc.
b. Spare prosthetic devices
c. Routine maintenance of the prosthetic device

d. Experimental prosthetic devices
e. Prosthetic devices ordered or purchased before the effective date of this coverage under this certificate
f. Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets.
g. Hearing aids

Radiology Services

Locations: The Plan pays for hospital, facility and physician diagnostic and therapeutic radiology services in:

a. A participating hospital
b. A participating facility
c. An office

The Plan pays for:

a. **Diagnostic Radiology Services**
   1. The Plan pays for facility and physician diagnostic radiology services. These services are used to diagnose disease, illness, pregnancy or injury. The services must be provided by your physician or by another physician if agreed on by your physician:
      A. X-rays
      B. Radioactive isotope studies and use of radium
      C. Ultrasound
      D. Computerized axial tomography (CAT) scans
      E. Magnetic resonance imaging (MRI)
      F. Positron emission tomography (PET) scans
      G. Medically necessary mammography

b. **Therapeutic Radiology Services**
   The Plan pays for physician's services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. This benefit covers the outpatient treatment of breast cancer. The services must be provided by your physician or, by another physician if agreed on by your physician.

The Plan does not pay for:

Procedures that are not related and needed to diagnose a disease, illness, injury or pregnancy (such as an ultrasound done only to find out the sex of a fetus).

Skilled Nursing Facility Services

Locations: The Plan will pay for the facility and professional services in a skilled nursing facility.

Requirements:

The Plan pays for an admission to a skilled nursing facility when:

a. The skilled nursing facility participates with BCBSM
b. The admission is ordered by the patient's attending physician

The Plan needs written confirmation from your physician that skilled care is needed.

Length of Stay
The Plan pays only for the period that is necessary for the proper care and treatment of the patient. The maximum length of stay is 120 days per member, per calendar year.

The Plan pays for:
a. A semiprivate room, including general nursing service, meals and special diets
b. Special treatment rooms
c. Laboratory examinations
d. Oxygen and other gas therapy
e. Drugs, biologicals and solutions
f. Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
g. Durable medical equipment used in the facility or outside the facility when rented or purchased from the facility upon discharge
h. Physician services (up to two visits per week)
i. Physical therapy, speech and language pathology services or occupational therapy when medically necessary

The physical and occupational therapy or speech-language pathology services that are performed in a skilled nursing facility are considered inpatient benefits. The 60-visit benefit maximums apply only when these services are provided on an outpatient basis.

The Plan does not pay for:
a. Custodial care
b. Care for senility or developmental disability
c. Care for substance use disorder
d. Care for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)
e. Care provided by a nonparticipating skilled nursing facility

Special Medical Foods for Inborn Errors of Metabolism

The Plan pays for:
Special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by a physician after he or she has done a complete medical evaluation of the patient's condition.

The following criteria must be met:
a. The cost of special medical foods must be higher than the cost of foods or items that are not special medical foods
b. Medical documentation must support the diagnosis of a covered condition that requires special medical foods
c. BCBSM determines which conditions are payable

To be paid, you must submit the prescription from the treating physician along with receipts for your special medical food purchases to BCBSM. Mail your receipts along with a "Member Application for Payment Consideration" to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd
Imaging and Support Services, MC 0010
Detroit, MI 48226-2998

You can obtain the above-mentioned form by visiting the Web site at www.bcbsm.com and clicking on "Member Forms" under the "Member Secured Services" tab. If you cannot access the Web site or you have trouble finding what you need, please contact BCBSM Customer Service.

The Plan does not pay for

a. Nutritional products, supplements, medical foods or any other items provided to treat medical conditions that are not related to the treatment of inborn errors of metabolism
b. BCBSM determines what conditions are related to inborn errors of metabolism.
c. Foods used by patients with inborn errors of metabolism that are not special medical foods, as defined by this Plan.
d. Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs

Speech and Language Pathology

Locations: The Plan pays for facility and professional speech and language pathology services:

a. A participating hospital (inpatient or outpatient)
   Inpatient therapy given in a hospital must be used to treat the condition for which the member is hospitalized.
b. A participating freestanding outpatient physical therapy facility
   The Plan pays freestanding facilities for physical therapy services. The Plan does not pay the person who provided the services.
c. An office
d. A member's home
e. A nursing home, if it's the member's primary residence
f. A participating skilled nursing facility

The Plan pays for:

a. The Plan pays for a maximum of 60 outpatient visits per member calendar year whether obtained from an in-network or out-of-network provider.

Important: See Note below about treatment dates and initial evaluations. This 60-visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:

1. Occupational therapy
2. Physical therapy (includes physical therapy by a chiropractor)
3. Speech Therapy
4. Chiropractic mechanical traction

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

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

Speech and language pathology services must be:

a. Prescribed by a professional provider licensed to prescribe speech and language pathology services
b. Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the patient and/or maintain the patient's level of functioning

    Given by:

    1. A speech-language pathologist certified by the American Speech-Language-Hearing Association or
    2. By one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

When a speech-language pathologist has completed the work for their master's degree, they begin a clinical fellowship for a year. In that year their work is supervised by a certified speech-language pathologist.

The Plan does not pay for:

b. Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought. The Plan may pay for treatment to improve cognition if the treatment is part of a comprehensive rehabilitation plan. The treatment must be necessary to treat severe speech deficits language and/or voice deficits. This treatment is for patients with certain conditions that have been identified by BCBSM.
c. Recreational therapy
d. Patient education and home programs
e. Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities. A BCBSM medical consultant may decide that speech and language pathology services can be used to treat chronic, developmental or congenital conditions for some children with severe developmental speech disabilities.
f. Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy or that is performed without a speech and language pathology treatment plan that guides and helps to monitor the provided therapy
g. Services provided by speech-language pathology assistants or therapy aides.
h. Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility
i. More than 60 outpatient visits per member per calendar year.
j. Services of a freestanding facility provided to you in the home or while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program

Substance Use Disorder Treatment Services

Locations: The Plan will pay for substance use disorder treatment services in:

a. A participating hospital
b. A participating residential or outpatient substance abuse rehabilitation facility
c. A participating outpatient psychiatric care (OPC) facility
d. An office

All services are subject to the conditions described below.

Substance use disorder treatment services that are the equivalent of an office visit are covered as an office visit.

a. **Inpatient Hospital Substance Use Disorder Treatment Services**

Services must be provided in a participating hospital.

The Plan pays for:

1. Acute detoxification. Acute detoxification is covered and paid as a medical service.

b. **Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services**

The Plan pays for substance use disorder treatment in a:

1. Participating residential substance abuse rehabilitation facility or
2. Participating outpatient hospital
3. Participating outpatient substance abuse rehabilitation facility.

The following criteria must be met:

A physician must find that you need substance use disorder treatment and note in the medical record if the treatment should be residential or outpatient.

A physician must:

1. Provide an initial physical exam
2. Diagnose the patient with a substance use disorder condition
3. Certify that the required treatment can be given in a residential or an outpatient substance abuse rehabilitation facility
4. Provide and supervise your care during subacute detoxification and
5. Provide follow-up care during rehabilitation

The services need to be medically necessary to treat your condition.

The services in a residential substance abuse rehabilitation facility must be preapproved by BCBSM.

They must also be provided by a participating substance abuse treatment facility.

The Plan pays for the following services provided and billed by an approved program:

1. Laboratory services
2. Diagnostic services
3. Supplies and equipment used for subacute detoxification or rehabilitation
4. Professional and trained staff services and program services necessary for care and treatment
5. Individual and group therapy or counseling
6. Therapy or counseling for family members
7. Psychological testing
8. Outpatient substance use disorder services for the treatment of tobacco dependence

The Plan also pays for the following in a residential substance abuse treatment program:

1. Room and board
2. General nursing services
3. Drugs, biologicals and solutions used in the facility

The Plan also pays for the following in an outpatient substance abuse treatment program:

1. Drugs, biologicals and solutions used in the program, including drugs taken home

The Plan does not pay for:

1. Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program
2. Diversional therapy
3. Services provided beyond the period necessary for care and treatment
4. Court ordered services
5. Treatment, or supplies that do not meet BCBSM requirements

c. **Outpatient Psychiatric Care Facility and Office Setting for Substance Use Disorder Services**
The Plan only pays for services in a participating outpatient psychiatric care (OPC) facility and office setting.

The Plan pays for:

1. Services provided by the facility's staff
2. Services provided by a physician, fully licensed psychologist, certified nurse practitioner, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologist, or licensed marriage and family therapist, or other professional provider as determined by BCBSM
3. Prescribed drugs given by the facility in connection with treatment

The Plan does not pay for:

1. Services beyond the period required to evaluate or diagnose mental deficiency, developmental disability, or intellectual disability
2. Services provided in a skilled nursing facility or through a residential substance abuse treatment program
3. Marital counseling
4. Consultations required by a facility or program's rule
5. Services provided by a nonparticipating outpatient psychiatric care facility

Surgery

Locations: The Plan pays for hospital, facility and professional services for surgery in:

a. A participating hospital, as an inpatient or an outpatient
b. A participating freestanding ambulatory surgery facility
c. An office

The Plan pays for:

a. **Presurgical Consultations**
If your physician tells you that you need surgery, you may choose to have a presurgical consultation with another physician. The consulting physician must be an MD, DO, podiatrist or an oral surgeon.

The consultation will be paid if the surgery you plan to have is covered under this Plan and will be done in a covered location (see above).

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

A. Second opinion — a consultation to confirm the need for surgery
B. Third opinion — allowed if the second opinion differs from the initial proposal for surgery
C. Nonsurgical opinion — given to determine your medical tolerance for the proposed surgery

b. **Surgery**

1. Physician's surgical fee
2. Medical care provided by the surgeon before and after surgery while the patient is in the hospital
3. Visits to the attending physician for the usual care before and after surgery
4. Operating room services, including delivery and surgical treatment rooms
5. Sterilization (whether or not medically necessary)
   As part of your preventive services, the Plan covers voluntary sterilization for females
6. Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration related to surgery
7. Cosmetic surgery is only payable for:
   A. Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
   B. Correction of deformities resulting from cancer surgery including reconstructive surgery after a mastectomy
   C. Conditions caused by accidental injuries, and
   D. Traumatic scars
   E. The Plan will not pay for cosmetic surgery and related services that are only to improve your personal appearance.
8. Dental surgery is only payable for:
   A. Multiple extractions or removal of unerupted teeth or alveoplasty when:
      i. A hospitalized patient has a dental condition that is adversely affecting a medical condition, and
      ii. Treatment of the dental condition is expected to improve the medical condition
   B. For surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ)
9. Multiple surgeries performed on the same day by the same physician are payable according to national standards recognized by BCBSM.
10. Technical surgical assistance (TSA): In some cases, a surgeon will need another physician to give them technical assistance. The Plan pays the approved amount for TSA, according to the Plans guidelines. The surgery can be done in a:
    A. Participating hospital (inpatient or outpatient)
    B. Participating ambulatory surgery facility

    A list of TSA surgeries that the Plan covers is available from your local BCBSM customer service center.

    The Plan does not pay for TSA:

    1. When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
    2. When services are provided in a location other than a hospital or ambulatory surgery facility

c. **Freestanding Ambulatory Surgery Facility Services**

The Plan pays for facility services in a BCBSM **participating** ambulatory surgery center. The services must be medically necessary. You must be a patient of a licensed MD, DO, podiatrist or oral surgeon to be admitted to the center. The services must be directly related to the covered surgery.

The following services are payable:

1. Use of ambulatory surgery facility
2. Anesthesia services and materials
3. Recovery room
4. Nursing care by, or under the supervision of, a registered nurse
5. Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery
6. Oxygen and other therapeutic gases
7. Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissue, as well as the cost of processing and storage
8. Administration of blood
9. Routine laboratory services related to the surgery or a concurrent medical condition
10. Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
11. Housekeeping items and services
12. EKGs

The Plan does not pay for:
Services by a nonparticipating ambulatory surgery facility

Temporary Benefits for Out-of-network Hospital Services

The following rules will apply when a participating hospital terminates its contract with BCBSM. These hospitals are sometimes referred to as "noncontracted" hospitals.

The Plan pays temporary benefits for some services of noncontracted hospitals. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for **six months** from the date the hospital terminates its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as they are medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM.

Mandatory Preapproval

You must obtain preapproval from BCBSM for any travel and lodging expenses before they occur. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs. Please call BCBSM to obtain preapproval.

BCBSM's customer service representatives can provide you and your physician with the telephone number to call for preapproval. If your request for preapproval of travel and lodging is for a bone marrow or organ transplant, ask your BCBSM customer service representative for the telephone number of the Human Organ Transplant Program.

Payable Services

a. Continuity of Care

Coverage Requirements

We will pay for your continued treatment in a hospital after it ends its participating contract with BCBSM. These benefits are available for up to six (6) months from the date the hospital end its contract with BCBSM when all of the following criteria are met:

1. You were undergoing a continued and regular course of treatment for the same condition at the same hospital or by a provider or team of providers on staff at the same hospital before the hospital ended its contract with BCBSM

2. BCBSM paid your claims for treatment of the same condition at the hospital before the hospital ended its participating contract with BCBSM

3. The services are medically necessary and would be covered if the hospital were a BCBSM in-network or participating hospital

Payment for Continuity of Care Services

We will pay our approved amount for covered services, less your cost-sharing requirements under this certificate. Our approved amount may be less than the hospital's bill. You may be required to pay the difference.

Payable Services

a. **Designated Services and Emergency Care**

1. **Coverage Requirements**

The Plan will pay for designated services and emergency care that you receive from a hospital that ends its contract with BCBSM when all of the following criteria are met:

A. The services are medically necessary and would be covered if the hospital were a BCBSM in-network or participating hospital

B.

C. The hospital that ends its contract with BCBSM is within 75 miles of your primary residence (this applies only to designated services)

2. **Payment for Designated Services and Emergency Care**

When the above coverage requirements are met, The Plan will pay you as follows:

A. Designated Services

The Plan will pay the Plans approved amount, less your cost sharing required under the Plan. The Plans approved amount may be less than the hospital's bill. You may be required to pay the difference.

B. Emergency Care

The below method is used to determine what The Plan pays for accidental injuries and emergency services.

The Plan pays the greater of the:

i. Median in-network rate the Plan pays for accidental injury or emergency service.

ii. Rate the Plan would pay a nonparticipating, out-of-network hospital for the accidental injury or emergency service. This rate is calculated using the method the Plan generally uses to set rates for these services from these types of providers.

iii. Medicare rate to treat the accidental injury or emergency service.
These rates calculated according to the requirements of the Patient Protection and Affordable Care Act.

The rate the Plan pays may be less than the hospital's bill. You may be required to pay the difference. You will not have to pay any out-of-network cost-sharing that apply to these services. However, you must pay any in-network cost-sharing that apply. In some cases, cost-sharing may be waived.

C. Transport from a Noncontracted Area Hospital
If you are receiving designated services or emergency care in a hospital that ended its contract with BCBSM, and your physician says that you are medically stable, you may choose to be transferred to the nearest participating hospital that can treat your condition. The Plan will pay the Plans approved amount to transport you by ambulance to that hospital.

If you use a nonparticipating ambulance service to transport you, their bill may be more than the Plans approved amount. You may be required to pay the difference.

If you transfer to a participating out-of-network hospital, you do not have to pay any out-of-network cost-sharing. But, you will still have to pay for any in-network cost-sharing.

The Plan will provide only limited coverage for emergency services at nonparticipating hospitals. The Plan provides you with no coverage if you are admitted on a nonemergency basis. If you decide to stay in a noncontracted hospital, the Plan will pay you at the nonparticipating rate. The Plans rate may be less than the hospital charges. You will have to pay the difference.

D. Limitations and Exclusions

i. If you get services from a hospital that ended its contract with BCBSM that are not designated services, The Plan will pay only the amount the Plan pays for nonparticipating hospital services. You will have to pay the difference between what The Plan pays and the hospital's charge. This difference may be substantial since the Plan does not pay for nonemergency services in a nonparticipating hospital.

ii. The Plan will pay for ambulance transport services only if they are for an admission that is covered under this Plan. If your Plan covers nonemergency transports, you will have to pay for your cost share.

b. **Travel and Lodging**
If you need to get services at an out-of-area hospital, The Plan will pay for the cost of travel and lodging if all of the following are met:
1. You live within 75 miles of the noncontracted area hospital
2. You cannot reasonably get covered services from:

A. A contracted hospital in your area or other participating provider within 75 miles of the noncontracted area hospital, and
B. Your physician directs you to an out-of-area hospital.
C. You get services from the out-of-area BCBSM in-network or participating hospital that is closest to the noncontracted area hospital

Payment will be subject to the following provisions:

1. Inpatient Services

If you need inpatient services from an out-of-area hospital, the Plan will pay a maximum of $250 per day for the reasonable and necessary cost of travel and lodging. The Plan will pay up to a total of $5,000 for travel and lodging costs for each admission. Both of these maximum payment amounts will cover the combined expenses for you and the person(s) eligible to accompany you. If you spend less than $250 per day or a total of $5,000 for all of your travel and lodging, the Plan will pay you the amount you actually spent. If you spend more than $250 per day or a total of $5,000, the Plan will only pay you the maximum of $250 per day or $5,000 total for your travel and lodging expenses.

Coverage will begin on the day before your admission and end on your date of discharge. The Plan will pay for the following:

A. Travel for you and another person (two persons if the patient is a child under the age of 18) to and from the out-of-area hospital
B. Lodging for the person(s) eligible to accompany you

2. Outpatient Services

If you need outpatient services from an out-of-area hospital or physician, the Plan will pay up to $125 for travel and lodging each time you need these services. Physician services must be directly related to your admission to an out-of-area hospital.

3. Limitations and Exclusions

A. The Plan does not pay for travel and lodging that were not preapproved, as previously described.
B. Travel and lodging will be paid only after you submit your original receipts to the Plan.
C. Travel does not include an ambulance transport to an out-of-area hospital.
D. The Plan will not pay for travel and lodging beyond the maximums stated above
E. The Plan will not pay for items that are not directly related to travel and lodging, such as:

Alcoholic beverages	Charges for hospital services not covered, e.g., private room	Household products	Movie rentals, Private room
Babysitters or daycare services	Clothing	Household utilities (including cellular telephones)	Security deposits
Books or magazines	Dry cleaning	Kennel fees	Stamps or stationery

Cable television	Flowers	Laundry services	Telephone, Television, Toiletries
Car maintenance	Greeting cards	Maids	Toys

F. Any other services, admissions or length of stay related to any of the above exclusions
G. The deductibles, copayments or coinsurances that you pay for other services, you will not have to pay for travel and lodging.

Transplant Services

Locations: Kidney, cornea, skin and bone marrow transplants are payable when performed in a:

a. Participating hospital
b. Participating ambulatory surgery facility

The plan covers transplants of specified organs such as heart or liver only if they are done in a "designated facility".

The Plan pays for:

Organ transplants and bone marrow transplants if the transplant recipient is a BCBSM member. Living donor and recipient transplant services are paid under the recipient's coverage.

a. **Organ transplants**

The Plan pays for services performed to obtain, test, store and transplant the following human tissues and organs:

1. Kidney
2. Cornea
3. Skin
4. Bone marrow (described below)

The plan covers immunizations against common infectious diseases during the first 24 months after your transplant. The Plan follows the guidelines of the Advisory Committee on Immunization Practices (ACIP).

The immunization benefit does not apply to cornea and skin transplants.

b. **Bone Marrow Transplants**

Bone marrow transplants require preapproval. If you do not get preapproval before you receive the transplant, neither it nor any related services will be covered and you will have to pay all costs. When they are directly related to:

1. Two tandem transplants
2. Two single transplants
3. A single and a tandem transplant

For each member and for each condition, The Plan pays the following services:

1. Allogeneic Transplants

A. Blood tests on first degree relatives to evaluate them as donors
B. 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.
C. Infusion of colony stimulating growth factors
D. 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:
   i. A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
   ii. 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.

   The Plan covers the donor's harvesting and storage when the recipient 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.
E. High-dose chemotherapy and/or total body irradiation
F. Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
G. T-cell depleted infusion
H. Donor lymphocyte infusion
I. Hospitalization

2. Autologous Transplants

A. Infusion of colony stimulating growth factors
B. Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
C. Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
D. High-dose chemotherapy and/or total body irradiation
E. Infusion of bone marrow and/or peripheral blood stem cells
F. Hospitalization

   A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. The Plan pays for up to two tandem transplants or a single and a tandem transplant per patient for this condition.

Allogeneic transplants are covered to treat only certain conditions. Please call BCBSM Customer Services for a list of these conditions.

Autologous transplants are covered to treat only certain conditions. Please call BCBSM Customer Services for a list of these conditions.

a. Additional services for bone marrow transplants:

In addition to the conditions listed above, The Plan will pay for services related to, or for:

1. High-dose chemotherapy
2. Total body irradiation
3. Allogeneic or autologous transplants to treat conditions that are not experimental

4. This does not limit or prevent coverage of antineoplastic drugs when Michigan law requires that these drugs be covered. The coverage includes the cost of administering the drugs.

The Plan does not pay the following for bone marrow transplants:

1. Services that are not medically necessary
2. Services provided in a facility that does not participate with BCBSM
3. Services provided by persons or groups that are not legally qualified or licensed to provide such services
4. Services provided to a transplant recipient who is not a BCBSM member
5. Services provided to a donor when the transplant recipient is not a BCBSM member
6. Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
7. Expenses related to travel, meals and lodging for donor or recipient
8. An autologous tandem transplant for any condition other than germ cell tumors of the testes
9. Search of an international donor registry
10. An allogeneic tandem transplant
11. 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
12. Experimental treatment
13. Any other services or admissions related to any of the above named exclusions

b. Specified Human Organ Transplants

Specified Human Organ Transplants require preapproval. If you do not get preapproval before you receive these services, it will not be covered and you will have to pay for it. However, once you get preapproval for the transplant, any services that you receive within one year from the date of the transplant will be covered as long as those services are medically necessary and related to the preapproved transplant.

When performed in a designated facility, the Plan pays for transplant of the following organs:

1. Combined small intestine-liver
2. Heart
3. Heart-lung(s)
4. Liver
5. Lobar lung
6. Lung(s)
7. Pancreas
8. Partial liver
9. Kidney-liver
10. Simultaneous pancreas-kidney
11. Small intestine (small bowel)
12. Multivisceral transplants (as determined by BCBSM)

The Plan also pays for the cost of getting, preserving and storing human skin, bone, blood, and bone marrow that will be used for medically necessary covered services.

All specified human organ transplant services must be provided during the benefit period if they are going to be paid by BCBSM. It begins five days before the transplant and ends one year after

the transplant. The only exceptions are anti-rejection drugs and other transplant-related prescription drugs.

When directly related to the transplant, The Plan pays for:

1. Facility and professional services
2. Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed; the payment for these drugs will be based on BCBSM's approved amount.
3. During the first 24 months after the transplant, immunizations against certain common infectious diseases are covered. Immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) are covered by BCBSM.
4. Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
   A. Occurs during the benefit period and
   B. Is a direct result of the organ transplant surgery

   The Plan will pay for any service that you need to treat a condition that is a direct result of an organ transplant surgery. The condition must be a benefit under this Plan.

The Plan also pays for the following:

Up to $10,000 for eligible travel and lodging during the initial transplant surgery, including:

1. 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)

2. In some cases, the Plan may pay for return travel to the original transplant facility if you have an acute rejection episode. The episode 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.

3. Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)
4. Cost of acquiring the organ (the organ recipient must be a BCBSM member.) This includes, but is not limited to:
   A. Surgery to obtain the organ
   B. Storage of the organ
   C. Transportation of the organ
   D. Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
   F. Payment for covered services for a donor if the donor does not have transplant services under any health care plan. The Plan will pay the BCBSM approved amount for the cost of acquiring the organ.

Limitations and Exclusions
During the benefit period, the deductible and copayments do not apply to the specified human organ transplants and related procedures.

The Plan does not pay for the following for specified human organ transplants:

1. Services that are not BCBSM benefits
2. Services provided to a recipient who is not a BCBSM member
3. Living donor transplants not listed in this document
4. Anti-rejection drugs that do not have Federal Food and Drug Administration approval
5. Transplant surgery and related services performed in a nondesignated facility
6. You have to pay for the transplant surgery and related services if you receive them in a nondesignated facility. If the surgery is medically necessary *and* approved by the BCBSM medical director, The Plan will pay for it.
7. Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
8. Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:

Alcoholic beverages	Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services	Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)	Mortgage or rent payments	Tips
Car maintenance	Furniture rental	Kennel fees	Reimbursement of food stamps	
Clothing, toiletries	Household products	Lost wages	Security deposits, cash advances	
Dry cleaning or laundry services	Household utilities (including cellular telephones)	Maids, babysitters or day care services	Services provided by family members	

9. Routine storage cost of donor organs for the future purpose of transplantation
10. Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this Plan
11. Experimental transplant procedures. See the "General Conditions of Your Contract" section for guidelines related to experimental treatment.

Urgent Care Services

The Plan pays for physician services provided at an urgent care facility.

Value Based Programs

Provider-Delivered Care Management (PDCM)
PDCM services are covered only when they are performed in Michigan by BCBSM designated providers. Under PDCM, a care manager will coordinate your care.

Locations: The Plan pays for professional services for PDCM in the following locations, subject to the conditions described below:
1. An office
2. A patriating outpatient hospital or participating facility

3. A members home
4. Other locations as designated by BCBSM

The Plan pays for:
Care management services identified by BCBSM only when performed by BCBSM-designated providers in Michigan

PDCM services may include:
1. Telephone, individual face-to-face, and group interventions
2. Medication assessments to identify:
    a. The appropriateness of the drug for your condition
    b. The correct dosage
    c. When to take the drug
    d. Drug Interactions
3. Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better

    Covered services are subject to change. Most PDCM services include support for setting goals and ensuring patient participation. The Plan encourages in-person contact between you and your care managers.

a. **Eligibility**

    You are eligible to receive PDCM services if you have:
    1. Active BCBSM coverage
    2. Agreed to actively participate with PDCM
    3. A referral for care management services from your physician
    4. Your physician will determine your eligibility and refer you for care management services based on factors, such as your:
        A. Diagnosis
        B. Admission status
        C. Clinical status

b. **Termination of Provider-Delivered Care Management**

    You may opt-out of PDCM at any time. BCBSM may also terminate PDCM services based on:
    1. Your nonparticipation in PDCM
    2. Termination or cancellation of your BCBSM coverage
    3. Other factors

The Plan does not pay for:
1. Services performed by providers who are not designated as PDCM providers
2. Services performed by providers outside the state of Michigan
3. For more information on PDCM services, contact BCBSM Customer Service.

c. **Blue Distinction Total Care (BDTC)**

BDTC services are covered only when they are performed by designated providers outside the state of Michigan and the member has an established relationship with the designated provider. Designated providers are identified by the local Blue Cross/Blue Shield plan in that state where the BDTC services are performed.

This section describes what the Plan covers under BDTC.

Locations: The Plan pays for professional services for BDTC in the following locations, subject to the conditions described below:

1. An office
2. A participating outpatient hospital or participating facility
3. A member's home
4. Other locations as designated by the local Blue Cross/Blue Shield plan in the state where the services are provided

The Plan pays for:

1. Services of out-of-state, providers who are designated by their local Blue Cross/Blue Shield plan to provide care management services

BDTC services may include:

1. Telephone, individual face-to-face, and group interventions

Medication assessments to identify:

1. The appropriateness of the drug for your condition
2. The correct dosage
3. When to take the drug
4. Drug Interactions

Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better

Covered services are subject to change.

Most BDTC services include support for setting goals and ensuring patient participation. The Plan encourages in-person contact between you and your care managers.

Eligibility

You are eligible to receive BDTC services if you have:

a. Active BCBSM coverage
b. Your physician will determine your eligibility and refer you for care management services based on factors, such as your:
    i. Diagnosis
    ii. Admission status
    iii. Clinical status

Termination of Blue Distinction Total Care

You may opt-out of BDTC at any time. The local Blue Cross/Blue Shield plan may also terminate BDTC services based on:

a. Your nonparticipation in BDTC
b. Termination or cancellation of your BCBSM coverage
c. Other factors

The Plan does not pay for:

a. Services performed by providers who are not designated by the local Blue Cross/Blue Shield plan as BDTC providers
b. Services performed in Michigan

For more information on BDTC services, contact BCBSM customer service.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan does not pay for services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan. The services listed in this section are in addition to all other nonpayable services stated in this document.

a. Noncontractual services described in your case management treatment plan when such services have not been approved by BCBSM

b. Gender reassignment services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational.

c. Court ordered services not otherwise covered by the Plan

d. Hospital admissions that are not acute, such as:
   1. Basal metabolism tests.
   2. Cobalt or ultrasound studies.
   3. Convalescence or rest care
   4. Convenience items
   5. Dental treatment, including extraction of teeth, except as otherwise noted in this Plan.
   6. Diagnostic evaluations.
   7. Electrocardiography
   8. Lab exams
   9. Observation
   10. Weight reduction.
   11. X-ray, exams or therapy.

e. Hospital services that the Plan does not pay for:
   1. Services that may be medically necessary but can be provided safely in an outpatient or office location.
   2. Custodial care or rest therapy.
   5. Psychological tests if used as part of, or in connection with, vocational guidance training or counseling.
   6. Outpatient inhalation therapy.
   7. Sports medicine, patient education or home exercise programs.

f. Facility services that the Plan does not pay for:
   1. Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.
   2. If a nursing home is your primary residence, then the Plan will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

g. Professional provider services that the Plan does not pay for:
   1. Services, care, supplies or devices not prescribed by a physician.
   2. Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children.

3. Services for cosmetic surgery when performed primarily to improve appearance, except as provided.
4. Weight loss programs (unless covered elsewhere in this certificate or otherwise required by law)
5. Services provided during nonemergency medical transport.
6. Experimental treatment.
7. Hearing aids or services to examine, prepare, fit or obtain hearing aids.
8. Services provided by persons who are not eligible for payment or appropriately credentialed or privileged (as determined by BCBSM) or providers who are not legally authorized or licensed to order or provide such services.

   If a participating BCBSM PPO in-network provider has not been credentialed to perform a service, they will be financially responsible for the entire cost of the service and cannot bill you for their services. They also cannot bill you for any deductibles, copayments, or coinsurance amounts. If you decide to get services from a nonparticipating/out-of-network provider who is not credentialed or privileged to perform a service, you will have to pay for the entire cost of the service.
9. Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens.
10. Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy).
11. Infertility services that do not treat a medical condition other than infertility. This can include services such as:

    A. Sperm washing.
    B. Post-coital test.
    C. Monitoring of ovarian response to ovulatory stimulants.
    D. In vitro fertilization.
    E. Ovarian wedge resection or ovarian drilling.
    F. Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility.
    G. Diagnostic studies done for the sole purpose of infertility assessment.
    H. Any procedure done to enhance reproductive capacity or fertility.

    You or your physician can call us to determine if other proposed services are a covered benefit under this Plan.
12. Sports medicine, patient education (except as otherwise specified) or home exercise programs.
13. Screening services (except as otherwise stated).
14. Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar non-hospital institution.

    If a nursing home is your primary residence, then the Plan will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.
15. Non-contractual services described in your case management treatment plan when such services have not been approved by BCBSM.

How Providers Are Paid

This section explains how BCBSM pays its providers and the people or facilities that provide services or supplies related to your medical care. They include, but are not limited to, hospitals, facilities, physicians, licensed labs, and health care professionals. Facilities include providers such as outpatient physical therapy facilities, clinics, ambulatory surgical centers and residential substance use disorder facilities. Health care professionals include providers that are not physicians, such as certified nurse midwives, physical therapists, audiologists, labs, home health care and home infusion care providers. BCBSM's PPO payment policy is shown in the chart below.

PPO In-network Providers	• In-network PPO providers have an agreement with BCBSM to provide services through the BCBSM PPO program. They have agreed to accept BCBSM's approved amount as payment in full for the covered services they provide. • BCBSM sends payment directly to in-network providers.
Out-of-Network Providers	• Out-of-network providers do not have an agreement with BCBSM to provide services through the BCBSM PPO program. • If you get services from an out-of-network provider, BCBSM will treat those services as out-of-network. Not all services are covered out-of-network. • Before you make an appointment with an out-of-network provider, you will need to find out if they are a participating or a nonparticipating provider with BCBSM. Here's why: o **Participating providers** — BCBSM sends payment of its approved amount directly to participating providers. They accept this payment amount as payment in full. o **Nonparticipating physicians and other health care professionals** — BCBSM sends payment directly to you. You will need to pay the provider. o **Nonparticipating hospitals** -- BCBSM does not pay for services from nonparticipating hospitals unless it's to treat accidental injuries or medical emergencies. Otherwise, you will need to pay most of the hospital's charges yourself. o **Nonparticipating facilities** -- BCBSM does not pay for services from nonparticipating facilities

BCBSM has agreements with different types of providers. Each type of provider has separate payment practices. In this section we describe payment practices for:

a. PPO In-network Providers
b. Out-of-Network Providers
c. BlueCard® PPO Program
d. Negotiated (non-BlueCard Program) National Account Arrangements
e. Blue Cross Blue Shield Global Core Program

PPO In-Network Providers (Hospitals, Facilities, Physicians and Health Care Professionals

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved Amount**	**Provider Payment**
You receive covered services from a PPO in-network provider.	You receive covered services from a PPO in-network provider.	BCBSM sends payment (the approved amount minus your in-network cost share) directly to the in-network provider.

What The Plan Pays and What You Pay

Plan pays	You pay for:	You do not pay for:

• The approved amount minus what you must pay	• In-network deductibles, coinsurances and copayments
	• Services not covered by your contract
	• Services that the Plan determines are not medically necessary or that are experimental
	• You may be billed only if:
	  o You acknowledge in writing before you receive the service that the Plan will not cover it because it is not medically necessary or it is experimental, and you agree to pay for the service, and
	  o The provider gives you an estimate of what the services will cost you.
	• Services when you do not give your provider the claim information in a timely manner. See General Conditions for timely filing.
		• Services that are not covered because the Plan determined that the provider did not have the required credentials or privileges to perform the services, or the provider did not comply with our policies when providing the services
		• An overpayment the Plan made to the provider
		• The difference between what we pay and what the provider charges

Out-of-Network Participating Providers (Physician and Health Care Professionals Not in the PPO Network)

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved Amount**	**Provider Payment**
You receive covered services from an out-of-network participating provider.	The provider **does not agree** to accept BCBSM's approved amount and your out-of-network cost share as payment in full for covered services.	BCBSM sends payment (the approved amount minus your out-of-network cost share) directly to you. You pay the provider.

What The Plan Pays and What You Pay

Plan pays	You pay for:	You do not pay for:
• The approved amount minus what you must pay	• Out-of-network deductibles, coinsurances and copayments and the difference between what we pay and what the provider charges (this amount is not applied toward your out-of-network cost-sharing requirements) • Services not covered by your contract • Services that we determine are not medically necessary or that are experimental	• Out-of-network cost-sharing requirements for the following services: o Exam and treatment for a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office o Treatment from a provider for which there is no PPO network. o Services from an out-of-network provider in an area of Michigan that we consider a "low-access area" for the provider's specialty. • You are responsible for your in-network cost share for these services.

To receive payment for covered services provided by a nonparticipating provider, you may need to send us a claim. Call your Customer Service representative for information on filing claims.

Some nonparticipating professional providers may agree to provide specific services on a claim-by-claim basis. This means that they will accept The Plan's payment, after your deductible, copayments and coinsurances have been met, as payment in full for a service they have provided. The provider may submit a claim to BCBSM and The Plan will send the payment to the nonparticipating provider.

The out-of-network nonparticipating providers listed below do not participate with BCBSM on a per claim basis:

a. Independent physical therapists
b. Certified nurse practitioners
c. Independent occupational therapists
d. Independent speech-language pathologists
e. Audiologists

If you receive services that require preapproval from a provider who does not participate with BCBSM, and the provider does not get the preapproval before those services are received, you will have to pay the bill yourself. The Plan will not pay for it. It is important to make sure that the nonparticipating provider gets that preapproval before you receive the services. Providers who do not participate with BCBSM and "nonparticipating providers" can include out-of-state providers; regardless of their participation with the plan where your services are being rendered.

Out-of-Network Participating Hospitals and Facilities Performing Non-Emergency Services

How They Are Paid

Step 1	**Step 2**	**Step 3**
Services	**Approved Amount**	**Provider Payment**
You receive covered services from a nonparticipating hospital or facility for treatment that is **not** for an urgent care, accidental injury or medical emergency.	The Plan **does not** pay for this type of service.	The Plan **does not pay** out-of-network nonparticipating hospitals or facilities for their services; you pay these providers their total charge.

Out-of-Network Participating Hospitals and Facilities Performing Emergency Services

How They Are Paid

Step 1	**Step 2**	**Step 3**
Services	**Approved Amount**	**Provider Payment**
You receive covered services from a nonparticipating hospital or facility for urgent care, treatment of an accidental injury or medical emergency.	The provider **does not** agree to accept BCBSM's approved amount as payment in full.	The Plan sends payment (the approved amount minus your in-network cost share) directly to you. You pay the provider.

What The Plan Pays and What You Pay

Plan pays	You pay for:	You do not pay for:
• The approved amount minus your in-network cost share for the treatment of an urgent care, emergency services or accidental injury.	• In-network deductible, coinsurances and copayments • The difference between what we pay and the amount charged by the provider (this amount is not applied toward your cost-sharing requirements)	• Out-of-network cost-sharing requirements for the following services: o Exam and treatment for a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office

Nonparticipating Hospitals and Facilities

The Plan does not pay for services at nonparticipating:
Hospitals

a. Outpatient physical therapy facilities
b. Outpatient psychiatric care facilities
c. Substance abuse rehabilitation facilities or residential treatment facilities
d. Psychiatric residential treatment facilities
e. Substance abuse residential facilities
f. Freestanding ambulatory surgery facilities
g. Freestanding ESRD facilities
h. Home health care agencies
i. Hospice programs
j. Long-term acute care hospitals
k. Skilled nursing facilities, or
l. Ambulatory infusion centers or home infusion providers.

If you need to know if a provider participates, ask your provider, the provider's admitting staff, or call BCBSM Customer Service.

BlueCard PPO® Program

BCBSM participates in inter-plan arrangements with other Blue Cross and/or Blue Shield Plans. These agreements operate under rules and procedures issued by the Blue Cross Blue Shield Association. This program offers medical benefits to Blue Cross and/or Blue Shield members when they are out of their local service area, such as out of state. The Blue Cross and/or Blue Shield Plan that pays for those covered services for you is your Host Plan. BCBSM will pay the Host Plan for the covered services it covered. However, the Host Plan is responsible for contracting with its participating providers and making sure they receive payment. All types of claims can be processed through these inter-plan arrangements, except for the following:

a. Dental care claims that are not paid as medical claims/benefits.
b. Prescription drug benefits or vision care benefits that are administered by a third party contracted by BCBSM to provide those specific service or services.

BlueCard PPO Network Providers

If you receive covered services from a Host Plan PPO network provider:

a. The provider will file your claim with the Host Plan.
b. The Host Plan will pay the provider according to its contract with the provider.

Network status is not based on provider participation with BCBSM. It is based on participation with the Plan where the services were provided.

When you receive covered services outside our service area and the claim is processed through the BlueCard Program, your deductible, copayment and coinsurance will be based on the lower of:

a. The amount the provider charged for your services or
b. The negotiated price that the Host Plan has made available to The Plan

This "negotiated price" will be one of the following:
a. A simple discount that reflects an actual price that the Host Plan pays to your provider.
b. An estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges.
c. An average price based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

The Host Plan will determine what pricing it will use. The Host Plan can negotiate with the provider to determine the price for each service. However, under the terms of the BlueCard Program, the price the Host Plan uses will be the final price that you are responsible for. There will be no pricing adjustment once that price has been determined.

Estimated and average pricing also includes adjustments BCBSM may need to make to estimates of past pricing for transaction changes noted above. These adjustments will not affect the price The Plan pays for your claim because they are not applied to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If you receive services in a state that imposes such a fee, BCBSM will calculate what you need to pay according to the applicable laws of that state.

BCBSM may process claims for covered services through a negotiated account arrangement with one or more Host Plans as an alternative to BlueCard. In those instances, the negotiated terms will determine the payment amount. Your cost share will be calculated based on the negotiated priced or the lower of either the billed amount or the negotiated price.

BCBSM has included a factor for bulk distributions from Host Plans in your premium for Value-Based Programs when applicable under this agreement.

If your coverage contains reference-based benefits, special rules apply. Reference-based benefits are those that have dollar limits for specific procedures. These limits are based on a Host Plan's local market rates. You will be responsible for paying the amount the provider bills above the specific reference benefit limit for a given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, you will incur no additional liability, other than any applicable cost sharing required in your certificate or riders.

BlueCard PPO Out-of-Network Providers

If the provider is not a Host Plan PPO network provider, and does not participate with the Host Plan, we will only pay our out-of-network provider amount, and you will be responsible for the difference, unless:

a. You were referred to that provider by a PPO network provider (You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network deductible requirements) or
b. You needed care for an accidental injury or a medical emergency (see Section 7 for the definition of emergency services).

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

Nonparticipating Providers Outside Service Area

An out-of-area provider that does not participate with the Host Plan may require you to pay for services at the time they are provided. If they do:

a. Call BCBSM Customer Service
b. Submit an itemized statement to us for the services.
c. The Plan will pay you the amount stated in this certificate for covered services provided by a nonparticipating provider. We do not pay for services of the nonparticipating facility providers listed in this section. The Plan provides very limited coverage for the services of nonparticipating hospitals.

In all cases, you are responsible for the out-of-network deductible, copayment and/or coinsurance payments that are covered in this certificate.

To find out if an out-of-area provider is a BlueCard or BCBSM PPO provider, please call 1-800-810-BLUE (2583). You may also visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com to see a list of participating providers.

Member Liability Calculation
When you receive covered services outside of our service area from nonparticipating providers, the amount you pay for these services will generally be based on either:

a. What the Host Plan pays its nonparticipating providers or
b. The price required by applicable state or federal law

In these cases, you may have to pay the difference between the amount the nonparticipating provider bills and the amount that BCBSM paid for the service.

Exceptions:
In some situations, we may use other payment methods to determine the amount we will pay for services rendered by nonparticipating providers.

These methods may include:
a. Billed covered charges
b. The payment we would make if the services were provided in our service area
c. A special negotiated payment

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount we will pay for the covered services.

Specialty Providers in the BlueCard Program

The Host Plan can pay for you to get medical care from providers who offer special services (e.g., Allergist, Chiropractor, Podiatrist) within the Host Plan's area, even if the provider offers a specialty that BCBSM does not cover. As long as the Host Plan contracts with the specialty provider, the services they provide to you will be paid.

BlueCard PPO Program Exceptions

The BlueCard PPO Program will not apply if:

a. The services are not a benefit under this certificate.
b. The provider specialty is not covered by BCBSM or the Host Plan.
c. This certificate excludes coverage for services performed outside of Michigan.
d. The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program.
e. You require the services of a provider whose specialty is not part of the BlueCard PPO Program, or
f. The services are performed by a vendor or provider who does not have a contract with BCBSM for those services.

Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, BCBSM may process your claims for covered services through an arrangement that we have negotiated with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the:

a. Negotiated price or
b. Lower of either the billed charges or the negotiated price that the Host Plan has made available to us

Blue Cross Blue Shield Global Core Program

If you are living or traveling outside of the United States, the Blue Cross Blue Shield Global Core Program will assist you in getting covered health care services. This program provides access to a worldwide network of inpatient, outpatient and professional providers and it also includes claims support services.

The Blue Cross Blue Shield Global Core Program is different from the BlueCard PPO Program in certain ways. For example, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of health care providers, the network does not have Host Plans. A PPO network is not available outside the United States.

In this section, references to participating or nonparticipating providers mean they participate or do not participate in the Blue Cross Blue Shield Global Core Program.

Medical Assistance Services

If you need medical services while traveling or living outside of the United States, contact the service center at 1-800-810-BLUE (2583) or Call 804-673-1177 collect, if you are calling from outside the United States

The center's staff will help you get the information about participating hospitals, physicians and medical assistance services. If you do not contact the service center, you may have to pay for all of the services that you receive.

Coverage for Blue Cross Blue Shield Global Core Participating Hospitals

Inpatient Hospital Services

If you need to be admitted to a hospital as an inpatient, call the service center to arrange for cashless access with a participating hospital. Cashless access means that you will only have to pay the in-network deductible(s) and copayment(s) for all covered services when you are admitted to the hospital. The hospital will file the claim with service center for you.

You are responsible for:
a. In-network deductible(s), copayment(s) and coinsurances
b. The payment of non-covered services
c. If you do not contact the service center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive
d. Submitting the international claim form(s), if you did not get cashless access
e. Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.

Outpatient Hospital Services

You are responsible for:
a. Paying for all of the outpatient services at the time they are provided
b. Submitting the international claim form(s)
c. Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com
d. Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Coverage for Blue Cross Blue Shield Global Core Nonparticipating Hospitals

Inpatient Hospital Services

If you need to be admitted to a nonparticipating hospital as an inpatient, call the service center to get a referral for cashless access. Cashless access means that you will only have to pay the out-of-network deductible(s) and copayment(s) for all covered services you receive when you are admitted to the hospital. The hospital will file the claim with the service center for you.

You are responsible for:
a. Out-of-network deductible(s), copayment(s) and coinsurances
b. The payment of non-covered services
c. If you set up cashless access, you will be responsible for the out-of-network deductible(s) and copayment(s) and non-covered services.
d. If you do not contact the service center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive.
e. Submitting the international claim form(s), if you did not get cashless access Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com
f. Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

It is your responsibility to contact BCBSM and get preauthorization for the services you will receive.

Outpatient Hospital Services

You are responsible for:

a. Paying for all outpatient services at the time they are provided
b. Submitting the international claim form(s). Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com
c. Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Emergency Services at Blue Cross Blue Shield Global Core Participating or Nonparticipating Hospitals

a. In the case of an emergency, you should go to the nearest hospital. If you are admitted, follow the process for inpatient hospital services.
b. If you are not admitted to the hospital, you must pay for all professional and outpatient services at the time they are provided.
c. You are responsible for submitting the international claim form(s). Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com
d. You must provide copies of your medical record, the itemized bill, and proof of payment along with the claim form. BCBSM will only pay for covered services.

Blue Cross Blue Shield Global Core Professional Services

a. You are responsible for payment of all professional services at the time they are provided.
b. You are also responsible for submitting the international claim form(s).
c. Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.
d. You must provide copies of your medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

GENERAL PROVISIONS

Coordination of Benefits

The plan coordinates benefits payable under this Plan per Michigan's Coordination of Benefits Act.

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.
The Plan Administrator and Claim Administrator may release to, and obtain from, any other insurer, plan, or party any information that it deems necessary for the purposes of this section. A Covered Person shall cooperate in obtaining information and shall furnish all information necessary to implement this provision.

In the event an individual is covered under the Plan as both a Participant and a Dependent, this Plan will be considered both the Primary Plan and the Secondary Plan for purposes of applying the Coordination of Benefits provision described in this section.

Definitions

The term "plan," as used in this section to refer to a plan other than this Plan, means any of the following providing benefits or services for health or medical treatment:

a. Group and nongroup insurance and subscriber contracts.
b. Health maintenance organization (HMO) contracts.
c.. Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured).
d. Medical care components of long-term care contracts, such as skilled nursing care.
e. Health benefits under group or individual automobile contracts.
f. Health benefits under group or individual motorcycle contracts.
g. Medicare or any other federal governmental plan, as permitted by law.

The term "plan" as used in this section does not include any of the following:
a. Hospital indemnity coverage benefits or other fixed indemnity coverage.
b. Accident only coverage.
c. Specified disease or specified accident coverage.
d. Limited benefit health coverage, as defined by state law.
e. School accident-type coverage.
f. Benefits for non-medical components of long-term care policies.
g. Medicaid policies
h. Medicare supplemental plans
i. Ancillary Services, e.g. dental, vision, hearing
j. Coverage under other federal governmental plans, unless permitted by law.

The term "Allowable Expense" means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering the Covered Person. Any expense that is not

covered by any plan covering the Covered Person is not an Allowable Expense. For example, the difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense unless one of the plans provides coverage for private Hospital room charges. Further, the amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with that plan's provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

The term "Primary Plan" means the plan that pays benefits first. The Primary Plan must pay benefits in accordance with its terms without taking into consideration the existence of another plan.

The term "Secondary Plan" means any plan that pays benefits after the Primary Plan. The Secondary Plan may reduce benefits so that the payments from all plans do not exceed 100% of the total Allowable Expense.

BCBSM will coordinate the benefits payable under this Plan pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this Plan are also covered and payable under another group health care plan, BCBSM will combine their payment with that of the other plan to pay the maximum amount that would routinely be paid for the covered services.

Coordination of Benefits Procedures

The Coordination of Benefits procedure determines how the benefits provided by the Plan will be coordinated with the benefits provided by any other plans covering a Covered Person for whom a claim is made.

The amount of expenses considered for benefits under this Plan, as a Secondary Plan, will only be the amount of eligible expenses not paid or reimbursed by the Primary Plan(s). Any expenses considered for benefits under this Plan are subject to all provisions stated in the Plan.

BCBSM has various calculation methods available for processing Coordination of Benefits (COB). These calculation methods are referred to as “ME TOO” by BCBSM. Oakland County utilizes the “ME TOO – G” secondary payment methodology. Step 1 is calculating the BCBSM primary payment and the resulting cost sharing (e.g. Deductible, Coinsurance, Copayment) for the Covered Person. Step 2 is the other carrier’s calculation of payment. The BCBSM Primary and Other Insurance Member Paid Amounts are compared and the difference is paid to the Employee, up to the BCBSM cost sharing amount.

Coordination with Other Coverage for Injuries Arising Out of Automobile Accidents

Notwithstanding the Payment Priorities rules set forth below, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, this Plan shall be the Primary Plan and the automobile insurance shall be the Secondary Plan for purposes of paying benefits.

Payment Priorities

Each plan makes its claim payment in the following order, if Medicare is not involved (except as provided in paragraph c. below):

a. A plan that contains no provision for coordination of benefits, states that its coverage is primary, or does not have the same rules of priority as those listed below shall be the Primary Plan and pay before all other plans, including this Plan, and this Plan shall have only secondary liability.

b. Except as provided in paragraph c., a plan that covers the claimant other than as a dependent (e.g., as an employee or retiree) shall pay before the plan that covers the claimant as a dependent.

c. If the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is (1) secondary to a plan covering the claimant as a dependent and (2) primary to a plan covering the claimant other than as a dependent (e.g. as a retiree), then, with respect to the two non-Medicare plans, the order in paragraph b is reversed so that:

1. The plan covering the claimant as a dependent is primary; and
2. The plan covering the claimant other than as a dependent is secondary.

In other words, in this situation, the plan covering the claimant as a dependent pays first, Medicare pays second, and the plan covering the person other than as a dependent pays third.
See the Coordination With Medicare section for information regarding when this Plan is primary or secondary to Medicare under federal law.

d. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

1. If the dependent child's parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is the Primary Plan. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan. This process is known as the "birthday rule".

2. If the dependent child's parents are divorced or separated or are not living together, whether or not they have ever been married, payment shall be made as follows:

A. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan. This rule applies to plan years commencing after that plan is given notice of the court decree.

B. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule will determine the order of benefits.

C. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule will determine the order of benefits.

D. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. The plan covering the custodial parent.
ii. The plan covering the spouse of the custodial parent.
iii. The plan covering the non-custodial parent.
iv. The plan covering the spouse of the non-custodial parent.

For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation shall be considered the custodial parent.

For purposes of this subsection, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

3. If the dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions of this subsection shall determine the order of benefits as if those individuals were the parents of the child.

e. The plan that covers the claimant as an active employee or dependent of an active employee shall pay before the plan that covers the claimant as an inactive employee (e.g., an employee who is laid off or retired) or dependent of such an inactive employee. This rule does not apply if the rules under paragraphs b. or c. can determine the order of benefits.

f. If a claimant has coverage provided under COBRA or under a right of continuation by state or other federal law ("continuation coverage") and also has coverage under another plan, the plan covering the claimant as an employee or retiree (or as the dependent of an employee or retiree) is the Primary Plan and the continuation coverage is the Secondary Plan. This rule does not apply if the rules under paragraphs b. or c. can determine the order of benefits.

g. Covered Persons eligible for Medicaid shall be subject to the following provisions with respect to a state Medicaid program:

1. The Plan will pay benefits with respect to a Covered Person in accordance with any assignment of rights made by or on behalf of the Covered Person under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid).
2. The Plan will not take into account the fact that an individual is eligible for or receives Medicaid assistance when considering eligibility for coverage or when determining or making benefit payments under the Plan.
3. To the extent payment has been made under Medicaid in any case in which the Plan has a legal liability for such payment, then payment under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person for such payment.

h. If the order set out in paragraphs A. through G. above does not apply in a particular case, the plan that has covered the claimant for the longest period of time shall pay first. To determine the length of time a person has been covered under a plan, two or more successive plans shall be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan's coverage ended.

These coordination of benefit rules are intended to follow the National Association of Insurance Commissioners (NAIC) group coordination of benefits model regulation. The Plan's coordination of benefit rules shall be interpreted accordingly. To the extent the NAIC model regulation is subsequently amended, the Plan's coordination of benefit rules shall be amended accordingly.

The Plan Administrator has the right to do the following:

a. Obtain from or share information with an insurance company or other organization regarding coordination of benefits, without the claimant's consent.

b. Require that the claimant provide the Plan Administrator with information regarding other plans in which the claimant may participate or be eligible to participate so that this provision may be implemented. A claimant's intentional nondisclosure under this provision shall constitute a misrepresentation in a claim for benefits for purposes of the Termination of Coverage section.

c. Pay the amount due under this Plan to an insurer or other organization if necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

Facility of Payment

Whenever a Covered Person or provider to whom payments are directed becomes mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor the Trustee, if any, shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, the Employer, and Trustee, if any, shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Payments may be made in any one or more of the following ways, as determined by the Plan Administrator in its sole discretion:

a. Directly to the Covered Person or provider.
b. To the legal representative of the Covered Person or provider.
c. To a Close Relative or other relative by blood or marriage of the Covered Person or provider.
d. To a person with whom the Covered Person or provider resides.
e. By expending the amount directly for the exclusive benefit of the Covered Person or provider.

Coordination with Medicare

IMPORTANT: Individuals receiving Retiree coverage under the Plan who are eligible for Medicare (except as otherwise required by law when Medicare is due to End Stage Renal Disease [ESRD]) may not be eligible for coverage under this Plan.

The Plan must provide benefits in accordance with the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," that includes parts A and B of Subchapter XVIII of the Social Security Act, as amended, and any other applicable federal laws or regulations. If the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations, including allowing the Plan to become secondary to Medicare. As used in this section, the term "current employment status" has the same meaning as under 42 CFR 411.104.

If a Covered Person is also eligible for Medicare, whether this Plan or Medicare is the primary payer depends upon the reason for the Covered Person's Medicare eligibility.

a. If the Medicare eligibility is because of Total Disability, this Plan will be the Primary Plan and Medicare the Secondary Plan if the Employer had 100 or more full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year and the Participant's coverage is based on current employment status.
   On the other hand, if the Employer had fewer than 100 full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year, or if the Participant's coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree coverage), Medicare will be the Primary Plan and this Plan will be the Secondary Plan.

   If a Participant has a Dependent who is Totally Disabled, these same coordination of benefits rules will apply to the Dependent.

c. If the Medicare eligibility is because the Participant or the Participant's Dependent spouse attains age 65, Medicare will be the Primary Plan and this Plan will be the Secondary Plan if the Participant's coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree coverage).

   On the other hand, if the Participant's coverage continues to be based on current employment status after attaining age 65, this Plan will be the Primary Plan and Medicare the Secondary Plan unless the Participant declines primary coverage under this Plan.

   If a Participant has a Dependent spouse who attains age 65, these same coordination of benefits rules will apply to the spouse.

d. For purposes of paragraphs a. and c., "Employer" includes any entity that is a member of Plan Sponsor's affiliated service group, as defined in Section 414(m) of the Code, and any entity that is at least 50% commonly owned with Plan Sponsor as defined in subsections (a) or (b) of Section 52 of the Code. If, as a result of the rules under paragraphs a., b., or c. of this section, Medicare is secondary to a plan covering the Covered Person as a Dependent and primary to a plan covering the Covered Person other than as a Dependent (e.g., as a retiree), then the rule under paragraph c. of the Payment Priorities section shall determine the order of the benefits.

As stated above, federal law prescribes these rules; if the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations. See the Plan Administrator for details.

End Stage Renal Disease (ESRD)

The Plan coordinates with Medicare to pay for ESRD treatment. This includes hemodialysis and peritoneal dialysis. The member should apply for Medicare to keep costs down. Dialysis services must be provided in:

a. A participating hospital

b. A participating freestanding ESRD facility

c. In the home

The member should apply for Medicare to keep costs down; otherwise he or she will be responsible for paying the cost of ESRD treatment.

When Medicare Coverage Begins

If you have ESRD, your Medicare starts on the first day of the fourth month of dialysis. Example: Dialysis begins February 12. Medicare coverage begins May 1. The time before Medicare coverage begins is the “Medicare waiting period.” It lasts for three months.

There is no waiting period if you begin self-dialysis training within three months of when your dialysis starts. If so, Medicare coverage begins the first day of the month you begin dialysis.

There is no waiting period if you go in the hospital for a kidney transplant or services you need before the transplant. (The hospital must be approved by Medicare.) Medicare coverage begins the first day of the month you go in. You must receive your transplant within three months of going in the hospital.

Sometimes transplants are delayed after going in the hospital. If it is delayed more than two months after you go in the hospital, Medicare coverage begins two months before the month of your transplant.

When BCBSM Coverage is the Primary or Secondary Plan

If you have BCBSM group coverage through your job and you are entitled to Medicare because you have ESRD, BCBSM is your primary plan. That means BCBSM pays for all covered services for up to 33 months. (The three months "waiting period" and 30 months "coordination period".) After the coordination period, Medicare is your primary plan and pays for all covered services.

The coordination period may be less than 30 months. The medical evidence report your physician fills out helps determine how long it is.

Dual Entitlement

If you have dual entitlement to Medicare and have employer group coverage, the following applies:

a. If you are entitled to Medicare because you have ESRD and your entitlement starts at the same time or before you are entitled to Medicare because of your age or disability, your employer health plan is the primary plan. It is primary until the end of the 30-month coordination period.

   Example: You retired at age 62 and kept your employer health plan as a retiree. You start dialysis on June 12, 2014. (This begins the three-month waiting period.) On Sept. 1, 2014 you become entitled to Medicare because you have ESRD. (This begins the 30-month coordination period.) Your 65th birthday is in February 2015. On your birthday you also become entitled to Medicare because you turn 65. Since you turned 65 during the 30 months (instead of before), your employer plan is your primary plan for the entire 30 months. On March 1, 2017 Medicare becomes your primary plan.

b. If you become entitled to Medicare because you have ESRD after you are entitled to Medicare because of your age or disability:

   Your employer health plan is your primary plan for the 30 month coordination period if:

   i. You are "working aged"

   ii. You are "working disabled"

   Example: You became entitled to Medicare in June 2012 when you turned 65. You are still working. You have employer health coverage. Your employer coverage is your primary plan. On May 27, 2014, you are diagnosed with ESRD and begin dialysis. On Aug. 1, 2014 (after 3 months) you again become entitled to Medicare because you have ESRD. Your employer health plan remains your primary plan through Jan. 31, 2017. Medicare becomes primary on Feb. 1, 2017.

c. If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

   Example: You retired at age 62. You have employer health coverage as a retiree. You turn 65 in August 2014 and become entitled to Medicare. Medicare is now your primary plan. You are diagnosed with ESRD in January 2015. You start dialysis. On April 1, 2015, you again become entitled to Medicare because you have ESRD. Medicare remains your primary plan permanently.

Coverage for Drugs and Devices

The Plan does not pay for a drug or device prescribed for uses or in dosages other than those approved by the Food and Drug Administration. (This is called the off-label use of a drug or device.) However, the Plan

will pay for them and the reasonable cost of supplies needed to administer them, if the prescriber proves that the drug or device is recognized for treatment of the condition it is prescribed for by:

a. The American Hospital Formulary Service Drug Information
b. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
c. Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Chemotherapeutic drugs are not subject to this general condition. If a prescription is for a contraceptive drug or device, the prescriber must show why all other contraceptives covered under the member's benefits cannot be used by the member.

Deductibles, Coinsurance and Copayments Paid Under Other Certificates

The Plan does not pay any cost sharing you must pay under any other certificate. An exception is when the Plan must pay them under coordination of benefits requirements.

Enforceability of Various Provisions

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

Experimental Treatment

a. Experimental treatment. This includes experimental drugs and devices
b. Services, drugs, devices, and administrative costs related to experimental treatment
c. Costs of research management.

See "Clinical Trials (Routine Patient Costs), "Oncology Clinical Trials" and "Services That Are Payable" below for exceptions.

The Plan does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

How BCBSM Determines If a Treatment Is Experimental

BCBSM's medical director determines whether a treatment is experimental. The director may decide it is experimental if:

a. Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
b. It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
c. Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
d. There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or

e. It is being studied in an on-going clinical trial, or
f. The treating provider uses a written informed consent that refers to the treatment, as:
   Experimental or investigational or
   Other than conventional or standard treatment.

The medical director may consider other factors. When available, these sources are considered in deciding if a treatment is experimental under the above criteria:

a. Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)
b. Information from the Blue Cross and Blue Shield Association or other local or national bodies
c. Information from independent, nongovernmental, technology assessment and medical review organizations
d. Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
e. Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
f. Accepted national standards of practice in the medical profession
g. Approval by the hospital's or medical center's Institutional Review Board

The medical director may consider other sources.

Services That Are Payable
We do pay for experimental treatment and its related services when all of the following are met:

a. BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
b. It is covered under your certificate when provided as conventional treatment.
c. The services related to the experimental treatment are covered under your certificate when they are related to conventional treatment.
d. The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM), or the related services are routine patient costs that are covered under "Clinical Trials (Routine Patient Costs)"
e. This certificate does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

a. This general condition does not add coverage for services not otherwise covered under the Plan
b. Drugs or devices given to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, we will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Fraud, Waste, and Abuse

The Plan does not pay for the following:

a. Services that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;
b. Services that are performed by a provider who is sanctioned at the time the service is performed.
c. Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

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

Genetic Testing

We will not:
a. Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
b. Request or require genetic testing of anyone covered under this certificate
c. Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
d. Limit coverage based on genetic information related to you, your spouse, or your dependents

Improper Use of Contract

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

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

Payment of Covered Services

The services covered under this Plan may be combined and paid according to BCBSM's payment policies. Examples include multiple surgeries or a series of lab tests.

Personal Costs

The Plan does not pay for:
a. Transportation and travel, even if recommended by a licensed practitioner, except as provided in this certificate
b. Care, services, supplies or devices that are personal or convenience items
c. Charges to complete claim forms
d. Domestic help

Pharmacy Fraud, Waste, and Abuse

We do not pay for the following:
a. Prescription drugs that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;

b. Drugs prescribed by a prescriber who is sanctioned at the time the prescription is dispensed.
c. Sanctioned prescribers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.
d. The Plan will notify you if any prescriber you have received services from during the previous 12 months has been sanctioned. You will be given 30 days notice, after which we will not pay for drugs prescribed by the sanctioned prescriber.

Physician of Choice

You may continue to get services from the physician you choose. However, be sure to get services from an in-network physician to avoid out-of-network costs to you.

Preapproval

Some admissions and services must be approved before they occur. If they are not preapproved, you may have to pay their entire cost. It is important to make sure that your provider gets the preapproval before you receive services or are admitted to a hospital or facility that require preapproval.

If preapproval is not obtained:
a. In-state participating providers cannot bill you for the cost of the services.
b. Out-of-state or nonparticipating providers may require you to pay for the cost of the services.

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

Prior Authorization

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

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

Services Before Coverage Begins or After Coverage Ends

Unless this document states otherwise, the Plan does not pay for any services, treatment, care or supplies provided before your coverage under this certificate begins or after it ends. If your coverage begins or ends while you are an inpatient in an acute care hospital, our payment will be based on our contract with the hospital. It may cover:
a. The services, treatment, care or supplies you receive during the entire admission, or
b. Only the services, treatment, care or supplies you receive while your coverage is in effect.

The Plan pays for only the services, treatment, care or supplies you receive while your coverage is in effect if it begins or ends while you are:

a. An inpatient in a facility such as a hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, or
b. Being treated for an episode of illness by a home health agency, ESRD facility or outpatient hospital rehabilitation unit or other facility identified by BCBSM.

If you have other coverage when a facility admits or discharges you, it may have to pay for the care you receive before your BCBSM coverage begins or after it ends.

Services That Are Not Payable

The Plan does not pay for services that:

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

When Others are Responsible for Illness or Injury (Subrogation)

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if the Plan paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if the Plan paid benefits for that injury, you must agree to the following provisions:

a. All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse the Plan in full for benefits the Plan paid. The Plan’s share of any recovery extends only to the amount of benefits the Plan has paid or will pay to you or your representatives. For purposes of this provision, “you” includes your covered dependents, and “your representatives” include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is the Plan’s right of recovery.
b. The Plan is entitled under the right of recovery to be reimbursed for the Plan’s benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. The Plan’s right of recovery is not subject to reduction for attorney's fees and costs under the “common fund” or any other doctrine.
c. The Plan will not reduce its share of any recovery unless, in the exercise of the Plan’s discretion, the Plan agrees in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
d. You must cooperate in doing what is reasonably necessary to assist us with the Plan’s right of recovery. You must not take any action that may prejudice the Plan’s right of recovery.

e. If you do not seek damages for your illness or injury, you must permit the Plan to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell the Plan promptly that you have made a claim against another party for a condition that the Plan has paid or may pay benefits for, you must seek recovery of the Plan's benefit payments and liabilities, and you must tell the Plan about any recoveries you obtain, whether in or out of court. The Plan may seek a first priority lien on the proceeds of your claim in order to reimburse the Plan to the full amount of benefits the Plan has paid or will pay.

The Plan may request that you sign a reimbursement agreement and/or assign to the Plan (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. The Plan may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and the Plan may enforce its right of recovery by offsetting future benefits.

The Plan will pay the costs of any covered services you receive that are in excess of any recoveries made.

The Plan's rights of recovery and subrogation as described in this Section may be enforced by BCBSM or by any Local Plan that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which the Plan may subrogate or assert a right of recovery shall also include:

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

Contact the Plan if you need more information about subrogation.

Subscriber Liability

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

Workers Compensation

The Plan does not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by the County.

Provisional Payment of Disputed Claim

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Claim Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan's rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

GRIEVANCE AND APPEALS PROCEDURES

BCBSM wants you to be satisfied with how they administer your coverage. If you have a question or concern about how BCBSM processed your claim or request for benefits, you are encouraged to contact BCBSM Customer Service. The telephone number is on the back of your Blues ID and in the top right hand corner of your Explanation of Benefit Payments statements.

BCBSM has a formal grievance and appeals process. This process allows you to resolve issues that you could not resolve through BCBSM Customer Service. You can dispute an adverse benefit decision or a rescission of your coverage.

An adverse benefit decision includes a:

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

You may file a grievance or appeal about any adverse benefit decision or rescission. The dollar amount involved does not matter.

There are two sets of rules governing the grievance and appeals process for members. One set will apply if your employer is a self-funded state or local governmental unit. A different set will apply if your employer is not a state or local governmental unit. These rules are described below.

Because Oakland County is the Plan Administrator of a self-funded medical plan, the following applies:

If you file a grievance or appeal:

a. You will not have to pay any filing charges.
b. You may submit materials or testimony at any step of the process to help BCBSM in its review.
c. You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the BCBSM customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative for Appeal form. Complete it and send it with your appeal.
d. BCBSM has 30 days to give you the Plans final determination if your grievance involves a preservice adverse decision and 60 days if it involves a post service decision. You have the right to allow BCBSM additional time if you wish.
e. You do not have to pay for copies of information relating to BCBSM's decision to deny, reduce or rescind your coverage.
f. It should be noted that because the Plan is not subject to ERISA, the claimant's right to bring a civil action is not governed nor protected under Section 502(a) of ERISA.

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

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

a. We waive the requirement

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

Standard Internal Review Process

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

Mail your written grievance to:

BCBSM Appeals Unit
600 Lafayette East – Mail Code CS3A
Detroit, MI 48226-2998

Step 2: BCBSM will contact you to schedule a conference once BCBSM receives your grievance. During your conference, you can provide any other information you want BCBSM to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at BCBSM's office in Detroit during regular business hours. The written decision BCBSM gives you after the conference is BCBSM's final decision.

Step 3: If you disagree with BCBSM's final decision, or you do not receive a decision within 30 or 60 days after BCBSM gets your original grievance, depending on whether your grievance involves a pre-service or post-service adverse decision you may request an external review. See below for how to request an external review.

Standard External Review Process

Once you have exhausted BCBSM's standard internal review process, you or your authorized representative may request an external review. The standard external review process is as follows:

a. Within 127 days of the date you receive or should have received BCBSM's final decision, send a written request for an external review to the Department listed below. Mail your request and the required forms that BCBSM gives you to:

   Department of Insurance and Financial Services
   Office of General Counsel
   Health Care Appeals Section
   P.O. Box 30220
   Lansing, MI 48909-7720

   You may also contact the Department with your request by phone, fax or online:
   Phone: 877-999-6442
   Fax: 517-284-8837
   Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

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

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

Reviews of Medical Issues

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

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

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

Reviews of Nonmedical Issues

Step 1: If your request for review involves nonmedical issues and is appropriate for external review, the Department will conduct the external review.

Step 2: The Department will decide whether to uphold or reverse BCBSM's adverse decision and will notify you of its decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

If your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:

a. Your life or health, or

b. Your ability to regain maximum function

You may request an expedited internal review if you believe

a. BCBSM wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or

b. BCBSM failed to respond in a timely manner to a request for benefits AND

   1.

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

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

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

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

Expedited External Review Process

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

Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 1-877-999-6442 to request the forms required.

Your physician must show (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:

a. Your life or health, or

b. Your ability to regain maximum function

You may request an expedited external review if you believe:

a. BCBSM wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or

b. BCBSM failed to respond in a timely manner to a request for benefits AND

    1.

The process is as follows:

Within 10 days of your receipt of BCBSM's denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 1-877-999-6442 to request the forms required.

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

Step 2: Complete this form within 10 days of receiving our final adverse determination and mail it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact the Department with your request by phone, fax or online:
Phone: 877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

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

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

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

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

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

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

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

Requesting a Standard Pre-Service Review

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

Your request for a review must include:

a. Your contract and group numbers, found on your Blues ID card
b. A daytime phone number for both you and your representative
c. The patient's name if different from the member
d. A statement explaining why you disagree with BCBSM's decision and any additional supporting information

Once BCBSM receives your appeal, they will provide you with BCBSM's final decision within 30 days.

Requesting an Urgent Pre-Service Review

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

See above for the steps to follow to request an expedited external review. For more information on how to ask for an urgent review or simultaneous expedited external review, call the BCBSM customer service number listed on the back of your Blues ID card.

Need More Information?

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

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

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your employer is a state or local government, you can also contact the director of the Department of Insurance and Financial Services for assistance.

To contact the Director:
Call toll-free at 1-877-999-6442; or
Fax at 517-284-8837; or
Online at https://difs.state.mi.us/Complaints/ExternalReview.aspx; or

Mail to:
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

COMPLIANCE WITH HIPAA PRIVACY AND SECURITY RULES

Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Subject to obtaining written certification pursuant to the Certification of the Plan Sponsor provision (see below), the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor does not use or disclose that PHI except for the following purposes:

a. To perform Administrative Functions for the Plan.
b. To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.
c. To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR §164.504(0.

Conditions of Disclosure

The Plan Sponsor agrees to the following in regard to any PHI:

a. To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
b. To ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
c. To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.
d. To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.
e. To make a Covered Person's PHI available when he or she requests access in accordance with 45 CFR § 164.524.
f. To make a Covered Person's PHI available when he or she requests an amendment to same, and to incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.
g. To make available the information required to provide an accounting of disclosures of PHI to a Covered Person upon request in accordance with 45 CFR § 164.528.
h. To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.
i. To return or destroy all PHI received from the Plan if the PHI is still maintained in any form, if feasible, and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

To be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

a. To obtain premium bids from health plan providers to provide health coverage under the Plan.
b. To modify, amend, or terminate the Plan.

Adequate Separation Between the Plan and the Plan Sponsor

The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information

Pursuant to 45 CFR 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

In accordance with the HIPAA privacy rules, the Plan Sponsor authorizes and directs the Plan to disclose PHI to stop-loss carriers, excess-loss carriers, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess-loss coverage related to benefit claims under the Plan.

Other Uses and Disclosures of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

Participant Notification

Participants shall be notified of the Plan's compliance with the HIPAA privacy rules in a Notice of Privacy Practices.

PLAN ADMINISTRATOR

The Plan Administrator is charged with the administration of the Plan. The Plan Administrator shall have the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The Plan Administrator shall exercise its discretion in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator shall have the discretionary authority to construe and interpret the terms of the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator may delegate all or a portion of its duties under the Plan to one or more authorized officers and/or an administrative committee and may utilize the services of the Claim Administrator to assist with performing claim payment and other various administrative functions of the Plan.

NONDISCRIMINATION NOTICE UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT

Discrimination Is Against the Law

Oakland County complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oakland County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oakland County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Human Resources Department at 248-858-0530.
If you believe that Oakland County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Human Resources Department, Oakland County, 2100 Pontiac Lake Road, Waterford, MI 48328, Telephone: 1-248-858-0530 You can file a grievance in person or by mail, or e-mail. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Michigan Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-248-858-0530.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-248-858-0530-XXXX.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-248-858-0530..
Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܦܠܚܝܬܘܢ 1-248-858-0530.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-248-858-0530.
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-248-858-0530.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-248-858-0530.. 번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-248-858-0530.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-248-858-0530.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-248-858-0530.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-248-858-0530..
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-248-858-0530.まで、お電話にてご連絡ください。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-248-858-0530.
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-248-858-0530.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-248-858-0530.

AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

a. The Plan Sponsor shall have the right to amend this Plan at any time, in whole or in part, to take effect retroactively or otherwise. No amendment may retroactively reduce claims for any Covered Expenses that were incurred before the amendment unless necessary to conform the Plan to the requirements of the Code, regulations issued under the Code, and any other applicable laws or regulations.
b. The Plan Sponsor reserves the right at any time to terminate the Plan by action of the Board of Commissioners or other similar governing body of the Plan Sponsor.

In addition, the Plan shall automatically terminate upon the occurrence of any of the following events:

a. The adjudication of the Plan Sponsor as bankrupt.
b. A general assignment by the Plan Sponsor to or for the benefit of one or more of its creditors.
c. The merger or consolidation of the Plan Sponsor to another entity that is the surviving entity.
d. The consolidation or reorganization of the Plan Sponsor.
e. The sale of substantially all of the assets of the Plan Sponsor, unless the successor or purchasing entity adopts the Plan within 90 days thereafter.

If termination occurs, the Plan shall pay all benefits for Covered Expenses incurred before the termination date. Covered Persons shall have no further rights under the Plan.

MISCELLANEOUS

Free Choice of Physician

The Covered Person shall have free choice of any legally qualified Physician or surgeon.

Workers' Compensation Not Affected

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

Conformity with Law

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

Failure to Enforce

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at any other time, nor will such failure affect the right to enforce any other provision.

Entire Representation/No Oral Modifications

This single document sets forth the terms of the Plan and the Summary Plan Description and it supersedes all other documents. Any other descriptive or interpretive materials (such as benefit summaries) shall not change the terms of the Plan as set forth in this document. Further, the terms of the Plan may not be modified by any oral statements made by the Employer or any of its directors, officers, Employees, agents, or authorized representatives, including, but not limited to, the Claim Administrator.

No Vesting

There is no vested right to current or future benefits under this Plan. A Covered Person's right to benefits is limited to any Plan assets and to Covered Expenses incurred and submitted within the time limits set forth in the Claims Procedure provision and incurred and submitted before the earliest of the following:

a. An amendment to the Plan that limits or terminates such benefits.
b. Termination of the Plan.
c. Termination of coverage or participation.

Non-Assignability

The benefits payable under the Plan to a Covered Person are specific to the Covered Person and may be received only by the Covered Person. No benefits of the Plan shall be assigned to any person, corporation, entity, or party except for assignment to the federal government in accordance with back-up withholding laws or except as provided in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law that provides that the state has acquired the rights to payment with respect to a Covered Person. Any other attempted assignment shall be void. However, the Plan reserves the right to make payment of benefits, in its sole discretion, directly to a provider of services or the Covered Person. The Plan reserves the right, in its sole discretion, to refuse to honor the assignment of any claim to any person, corporation, entity, or party. This section shall not be interpreted to prevent direct billing for Covered Expenses by a provider to the Plan Administrator.

No Employment Rights

The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Employee to be continued in the employ of the Employer, nor shall this Plan interfere in any way with the right of the Employer to discharge any Employee.

Covered Persons' Right

Except as may be required by law, the establishment of this Plan and the Trust, if any, shall not be construed as giving any Participant or Dependent any equity or other interest in the assets, business, or affairs of the Employer; or the right to question or complain about any action taken by its officers, directors, or stockholders or about any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and Dependents shall be limited to their right to receive payment of their benefits from the Plan when the same becomes due and payable in accordance with the terms of the Plan.

Acts of Providers

Nothing contained in this Plan shall confer upon a Covered Person any claim, right, or cause of action, either at law or in equity, against this Plan for the acts of any provider (e.g., Hospital, Physician, nurse, pharmacist, etc.) from which the Covered Person receives services or care while covered under this Plan.

Recovery of Overpayment

If the Plan pays benefits that should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Claim Administrator shall have the right to recover such payment or excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

Acceptance/Cooperation

Accepting benefits under the Plan means that the Covered Person has accepted the Plan's terms and shall be obligated to cooperate with the Plan Administrator's requests to help protect the Plan's rights and carry out its provisions.

Time Limit for Filing Claims

These claims are professional and facility claims for medical services. They do not include claims for prescription drugs received from pharmacies or for dental or vision services that are not covered under this certificate. The Plan will not pay for claims that are not filed within the following time limits from the date of service:

a. For participating provider claims, the Plan will not pay medical claims filed after the timefame set out in your treating provider's participation agreement with BCBSM.
    1. 180 days (for professional claims)
    2. 12 months (for hospital and facility claims)
    3. 15 months (for home infusion therapy claims)
    4. Or after the service because you did not furnish the provider with information needed to file a claim

b. For nonparticipating providers, the claims must be submitted within 24 months from the date of service

Time Limit for Legal Action

Legal action against the Plan may not begin later than three years after the Plan has received a complete claim for services. No action or lawsuit may be started until 30 days after you notify the Plan that the Plans decision under the claim review procedure is unacceptable.

Unlicensed and Unauthorized Providers

Benefits are not payable for health care services provided by persons who are not appropriately credentialed or privileged (as determined by BCBSM), or legally authorized or licensed to order or provide such services.

What Laws Apply

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

Release of Information

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

The plan agrees to keep this information confidential. Consistent with the Plans Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

Verbal verification of a member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, and the availability of benefits at the time the claim is processed, as well as to the conditions, limitations, exclusions, maximums, deductibles and copayments under your coverage.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by the Plan and a more expensive room selected by the member.

CONTACT INFORMATION

This section lists phone numbers and addresses to help you get information quickly. You may call or visit the Plans BCBSM Customer Service Center.

To Call

Most of the Plans BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon from 1 to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Nationwide toll-free 1-877-790-2583

For when you are out-of-state, call BlueCard 1-800-810-2583

For when you are out of the country, call BlueCard Worldwide .....1-804-763-1177 (call collect)

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit BCBSM's website at bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit
600 E. Lafayette Blvd., Detroit 48226 (Downtown, three blocks north of Jefferson at St. Antoine)

Flint
4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids
86 Monroe Center N.W., Grand Rapids 49503

Holland
151 Central Ave., Holland 49423

Lansing
232 S. Capitol Ave., Lansing 48933

Marquette
415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage
8175 Creekside Dr., Suite 100, Portage 49024

Traverse City
City Centre Plaza
202 State St., Traverse City 49686

Shelby Township
6100 Auburn Road, Shelby Township 48317 Diagonally across from the AAA building