Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MARSH & MCLENNAN AGENCY LLC COMPANY
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Effective Date: 01/01/2025

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Prior authorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are 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 medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,000 for a one-person contract or $4,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract or $8,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	20% of approved amount for most covered services	40% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$4,000 for a one-person contract $8,000 for a family contract (two or more members) each calendar year	$8,000 for a one-person contract $16,000 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits	In-network	Out-of-network
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) • 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	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• 80% after in-network deductible for each office visit (in person or virtual) • 80% after in-network deductible for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM-selected vendor	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	80% after in-network deductible	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible Limited to a maximum of 90 days per member per calendar year	80% after in-network deductible
Hospice care	80% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	80% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	80% after in-network deductible - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services must be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	80% after in-network deductible	60% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	

Benefits	In-network	Out-of-network
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	60% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible	60% after out-of-network deductible
Private duty nursing care	80% after in-network deductible	60% after out-of-network deductible

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Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $20 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $80 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay plus an additional 20% of the BCBSM approved amount

Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $160 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $160 copay	After deductible is met, you pay $160 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay 15% of the approved amount, but no more than $150 **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible is met, you pay 25% of the approved amount, but no more than $300 **Note:** No coverage for 31-90 day supply.			

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.
* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Elective lifestyle drugs	Benefits are excluded for elective lifestyle drugs. **Note:** Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.
Maximum allowable cost drugs	For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

READY TO HELP

MICHIGAN

Member Handbook

Revised January 2025

Welcome

Thank you for choosing Blue Cross Blue Shield of Michigan. This *Member Handbook* will help you and your family get the most from your health plan. By being well-informed, you'll have the confidence and security of knowing health care coverage is available when you need it.

This handbook gives an overview of your health care coverage. For more details about your coverage:

- Visit **bcbsm.com** and click *Login*.
- Register to create an account.

If you have technical difficulties, call Web Support at **1-888-417-3479**.

To request a hard copy of this handbook, call the Customer Service number on the back of your Blue Cross member ID card.

The information in this handbook is a summary of your group's health care benefits. It's not a contract. It may not reflect additional limitations or exclusions that apply to paid services or the most recent updates to Blue Cross certificates, riders, health plan modifications or changes that your group may be making to your coverage. Contact your health care administrator or call the Customer Service phone number on the back of your member ID card if you have questions about your health care benefits.

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Your Blue Cross member ID card

Your member ID card

Confidence comes with every card.®

You should receive your Blue Cross member ID card shortly after you have a health plan with Blue Cross.

Your member ID card tells doctors and other health care providers what your health plan includes and what Blue Cross Blue Shield of Michigan will pay for. You should always carry it with you, and make sure you have the latest card. Using outdated cards may delay payment of claims.

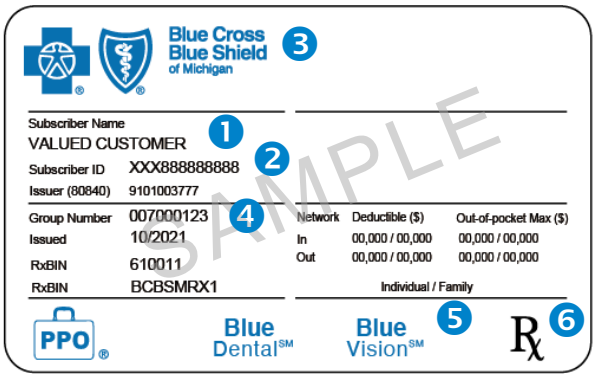
NOTE: All cards will show the subscriber's name, even those issued to family members. If you aren't the subscriber, your card won't have your name on it.

Below is a sample member ID card that highlights information you may need.

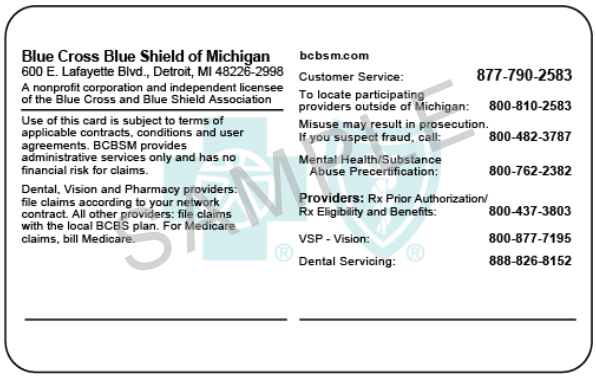
1. Member name: The subscriber's name
2. Member ID: The subscriber's assigned contract number, which allows health care providers to identify you and your benefits
3. Issuer: Identifies you as a Blue Cross member from Michigan to out-of-state providers
4. Group number: Identifies your employer group
5. & 6. These icons are present if your coverage includes dental, vision or prescription drugs

Customer service phone numbers for you and your providers are on the back of your member ID card.

Card front



Card back



About your member ID card

Only you and your eligible family members may use the cards issued for your contract. Lending your card is illegal and subject to possible fraud investigation and termination of coverage.

Call us if your card is lost or stolen. Your health care providers can call us to verify coverage until you receive your new cards.

If you need additional ID cards:

- Visit **bcbsm.com** and log in.
- Click *View now* under ID Cards & Proof of Coverage.
- Select *Order* under your ID card image and you'll receive two cards in the mail.

You can also call the Customer Service number on the back of your ID card.

Mobile app and online member account

Our mobile app and online member account provide resources to help you access your health plan’s information and make informed decisions about your health care from the convenience of your computer, tablet and phone.

Here are some features:

Health plan coverage: Review your health plan's benefits so you're more informed when you need care.

Deductible and out-of-pocket balances: Know how much you've paid toward your deductible and out-of-pocket maximum balances.

Access to pharmacy and drug information (for members with Blue Cross pharmacy coverage): Compare drug prices, locate a nearby pharmacy and order a 90-day supply of your daily medications.

View claims and EOBs: See what providers charged and why, before you pay. Quickly filter and search claims by time frame, member, service type or provider.

Find care: Look up doctors and places within your health plan’s network and see which have virtual visits and are accepting new patients. Compare quality, office hours, hospital affiliations and other information.

Compare cost estimates: Compare cost information for health care services based on your health plan's benefits.

Virtual member ID card: Show your virtual member ID card at your doctor's office for verification of coverage.

Web or mobile, get the most from your health plan

Health care can be confusing. To help you understand and manage your costs and care, we offer a wide range of tools through your online member account at **bcbsm.com**.

Register for your online member account

It only takes a few minutes to activate your account. Go to **bcbsm.com**, click *LOGIN* and follow the prompts.

You can also access your plan information by using our app.
To get our mobile app, search “BCBSM” in the App Store® or on Google Play™.

What can you find online or using the mobile app?

My Coverage – Find detailed health plan information, who is on your health plan, what we pay for, what you pay for and more.

My Claims – See a list of all claims.

ID Card – Request additional member ID cards or view a virtual one.

Find Care – This includes hospitals, urgent care, behavioral health services and 24-Hour Nurse Line.

Programs and Services – Find health care services and well-being resources that are available through your plan.

Spending Accounts – Review account balances and manage your health care spending account.

Forms and Documents – Get claim and reimbursement forms and many other helpful resources to manage your benefits and care.

Discounts – You’ll have access to money-saving programs, such as Blue365®. This national program offers access to discounts and savings from selected companies on health-related products and services.

Member discounts with Blue365®

Save money and live healthier with Blue365®

Save money and live healthier with Blue365

Blue Cross members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

Member discounts with Blue365 offers exclusive deals on:

- Fitness and wellness: Fitness gear and gym memberships
- Healthy eating: Meal delivery services and weight-loss programs
- Lifestyle: Travel and recreation
- Personal care: LASIK and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today. You can view a full list of discount offers from your Blue Cross member account.

For a full list of discounts, log in or register at **bcbsm.com** and click *Blue365 member discounts* under the *Programs & Services* tab. You can also access discounts on the go with the Blue Cross mobile app. Search “BCBSM” on Google Play™ or in the App Store® to download our mobile app.

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365®

Choosing your provider

Looking for a doctor, hospital or other health care professional?

You can choose any health care provider in your network for routine or general care. You don't need a referral for specialty or behavioral health care and hospital services. To help narrow your options, visit **bcbsm.com** and click *Find a Doctor* to choose a health care provider who best matches your needs and maximize the value of your health plan. With this application you can:

- Enter your preferred location
- Easily compare providers
- Review specialty, board certification and education information
- Find contact information
- Read a review of a doctor
- Print your search results
- Find out-of-state doctors
- Get cost estimates to help you research and compare certain procedures

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

- Primary care services (annual physicals or general health issues)
- Specialty care
- Behavioral care and substance use disorders
- Evening or weekend services
- Services from a doctor who speaks another language
- Hospital services near you

Services that need prior authorization

Services included in your coverage must be provided by Blue Cross-approved providers who are legally qualified or licensed to provide them. Depending on the health care services you need, your provider might have to get approval. For more information and a list of services that need approval, visit **bcbsm.com/importantinfo** and click *Services that need prior authorization*.

What is a network provider?

A network provider is a physician other health care specialist or hospital that provides services through our PPO network. PPO stands for preferred provider organization. PPO network providers have signed agreements with us to accept our allowed amount as payment in full for benefits under your health plan. Using PPO network providers limits your out-of-pocket costs for benefits under your health plan, including any deductible and copayments that may be required.

Special note for parents of students: Family members attending school away from home still need to choose a physician in the PPO network. (See the section on BlueCard®.)

Limited network

Certain types of providers — including speech pathologists, nursing facilities and others — are not in our PPO network, but the services are paid at the in-network level. If you aren't sure if a health care provider is considered in network under your health plan, call the Customer Service number on the back of your Blue Cross member ID card.

What is an out-of-network provider?

An out-of-network provider is a physician other health care specialist or hospital that hasn't signed an agreement to provide services through our PPO network. Your health plan generally has higher out-of-pocket deductible and copays for services received outside the PPO network.

Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our allowed amount plus your out-of-network deductible and copayment as payment in full for benefits under your health plan.

Nonparticipating providers haven't signed an agreement and can bill you for any differences between their charges and our allowed amount.

How providers are paid

How much you pay for services depends on whether you use an in-network or out-of-network provider. We'll explain the difference below.

Under your health plan, the payment allowed for benefits is called our allowed amount. This amount is the lower of the provider's billed charge or our maximum payment level. Any deductible or copays required by your health plan are subtracted from the allowed amount before we make our payment.

PPO network providers — Blue Cross pays network providers directly. Because of their signed agreement with us, network providers accept this payment as payment in full for benefits in your health plan. You're only responsible for your in-network deductible or copays that may be required by your health plan.

Choosing your provider

Out-of-network providers — If you go to a provider who isn't in our network, it's important to verify if the service is included in your health plan. Not all services outside the network are included. Call the Customer Service phone number on the back of your member ID card for verification of coverage.

When using out-of-network providers, you also need to find out if the provider participates with Blue Cross. Here's why this is important:

Participating providers — We pay participating providers directly. Because they have signed agreements with us, participating providers accept our payment as payment in full for services included in your health plan. You're responsible only for any out-of-network deductible or copays required by your health plan.

Nonparticipating providers — We send the payment directly to you, and it's your responsibility to pay the provider. Because our payment to you may be less than the provider's charge, you may also have to pay the difference between our payment and the provider's charge. This would be in addition to any out-of-network deductible or copay required by your health plan.

Nonparticipating hospitals, facilities and alternatives to hospital care providers — Our payment for services at nonparticipating hospitals is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means you'll need to pay most of the charges yourself and your bill could be substantial. Please refer to your health care certificate for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.

What you pay out of pocket

For details of the amount of out-of-pocket expenses you pay for health plan services:

- Visit **bcbsm.com** and log in.
- Click *My Coverage* and select either *Medical*, *Dental* or *Vision*.
- Click *What's Covered*.

If you have to pay for benefits included in your health plan, we'll reimburse you for our share of the cost. For more information and for a copy of the reimbursement form:

- Visit **bcbsm.com** and log in.
- Click *Forms*.
- Select *Reimbursement Forms* under *Claims*.
- Choose *Start a new claim for reimbursement online form* to begin the reimbursement process.

Keeping your health information secure

Expect confidentiality regarding your care. Blue Cross will adhere to strict internal and external guidelines concerning your personal health information. This includes the use, access and disclosure of all information that is of a confidential nature.

- Visit **bcbsm.com/importantinfo**.
- Click *Privacy Practices*.

Preventing fraud

If your provider asks for another form of identification, don't worry. This is just one way our providers help us protect you against unauthorized use of your member ID card.

You can also help prevent fraud by checking your explanation of benefits statement. If you see a discrepancy, contact your provider first to see if it’s an error. If it's not and you believe it’s fraudulent billing or use of your card, call our Anti-Fraud Hot Line at **1-800-482-3787**. You can also fill out our online anti-fraud form or write to:

Anti-Fraud Unit, Mail Code B759
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

When reporting fraud, all phone calls and correspondence are confidential.

Health resources

Blue Cross Well-Being℠

Blue Cross Well-Being offers online resources that can help you get and stay healthy. We work with Personify Health™ to offer you an enhanced well-being experience that includes:

- **Fitness tracking** — You can sync data from your fitness app or tracker to Blue Cross Well-Being. Seamlessly connect with more than 100 devices and apps, including Apple Health, Fitbit and MyFitnessPal.
- **Health assessment** — Learn your strengths as well as areas for improvement and get personalized recommendations.
- **Journeys®** — Over 60 lifestyle and health-related self-guided courses are available.
- **Tobacco Cessation Coaching** — If you're ready to stop smoking, vaping or using nicotine, this program pairs you with an experienced coach who offers support personalized to your specific interests and needs. The same coach stays with you throughout your journey to quit. You can connect with your coach by phone or through in-app messaging.
- **Daily Tip Cards** — Every day we'll send you two new tips to help you live well. Plus, we'll make sure they're about the areas that interest you the most.
- **Healthy habit trackers** — Get bite-size ways to build a healthy routine and improve your well-being. Your healthy habits will be customized based on your health assessment results and the interests you set in your profile.
- **My Care Checklist** — This handy health care tracker assists you in managing your health by keeping track of well visits, screenings and vaccinations — all in one place.
- **Nutrition Guide** — Choose what you'd like to work on, like cutting out sweets or portion control. Then get tips and recipes to help you achieve your goals.
- **Sleep Guide** — What's your sleep like? Decide what you need to work on, like getting to bed earlier or quieting down. Then get information to help you rest.

You can access these resources through your member account at **bcbsm.com** or our mobile app. Log in to your member account at **bcbsm.com** or on our mobile app. From **bcbsm.com**, click the *Programs & Services* tab. Then select *Blue Cross Well-Being* under *Quick Links*. From the app, select *Programs & Services*. Then select *Health Care & Well-Being*. Scroll down to *Blue Cross Well-Being*.

Personify Health is an independent company that provides health and well-being services on behalf of Blue Cross Blue Shield of Michigan.

Other resources

Blue Cross Virtual Well-Being℠

Blue Cross Virtual Well-Being offers live, 30-minute, interactive webinars on Thursdays at noon Eastern time focused on engaging and inspiring people to enhance their overall well-being. Every webinar includes a science-based discussion of well-being topics, such as menopause, functional fitness and learning to respond rather than react.

In addition to webinars, guided meditations are presented live each Wednesday at noon Eastern time. All webinars and meditations are also available on-demand. Register for webinars or meditations and learn more at **bluecrossvirtualwellbeing.com**.

Blue365®

Our member discount program gives you exclusive deals on health-related products and services, such as fitness gear, gym memberships, travel and personal care products. Log in to your member account to see available discounts.

Engagement Center

The answers you need are a phone call away. Our knowledgeable Engagement Center assistants can answer your questions about the well-being programs available to you.

Engagement Center assistants can also:

- Help you find network doctors and hospitals
- Answer questions about well-being program incentive requirements (for eligible participants)
- Give you information about program discounts
- Assist with online well-being resources
- Direct you to a registered nurse for health information and symptom management, when necessary (for eligible participants)

Call
1-800-775-BLUE (2583)
Monday through Friday
8 a.m. to 5 p.m.
Eastern time

All calls are toll-free and strictly confidential.

24-Hour Nurse Line

Our 24-Hour Nurse Line gives you access to registered nurses who are ready to answer your health care questions 24 hours a day, seven days a week.

You can talk to a nurse about:

- Symptom management
- Health information
- Audio health library

How to get started
Call 1-844-811-8460.

AHealthierMichigan.org

This blog site shares information on everything from good mental health to smoothie recipes and workout hacks. Visit **ahealthiermichigan.org** to explore.

BlueCard® Program

When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you can find network and participating providers throughout the U.S. and around the world.

And, like network and participating providers in Michigan, you won't have to fill out claim forms or pay up front for the cost of the service unless it's an out-of-pocket cost, such as a deductible or copayment, or a benefit that's not in your health plan.

Here are three steps to make the BlueCard program work for you:

1. In an emergency, go directly to the nearest hospital.
2. Call **1-800-810-BLUE (2583)** or visit **bluecardworldwide.com**.
3. When you arrive at the network or participating provider's office or hospital, present your Blue Cross member ID card. The doctor or hospital will recognize the suitcase logo on the front of the card and know you're receiving services under the BlueCard program. This means they'll submit any claim forms to us and only bill you for any deductible or copay that may be required by your health plan.

Care away from home

Within the US

When you're traveling, you're covered through our **BlueCard®** program. Blue Cross Blue Shield health plans have the largest hospital and physician networks in the U.S., with 97% of all U.S. hospitals and 85% of physicians. No matter where you live, work or travel, Blue Cross members, through BlueCard, can receive quality care. However, if the doctor or hospital is out of network, you could pay higher out-of-pocket costs.

To find a doctor or hospital outside of Michigan, you can use the *Find a Doctor* search tool at **bcbs.com**, download and log on to our mobile app, or call **1-800-810-2583**.

Outside the US

If you're traveling or living outside of the country, Blue Cross Blue Shield Global® Core gives you access to a worldwide network of traditional inpatient, outpatient and professional health care providers. The program includes a broad range of medical assistance and claim support services for members traveling or living in countries outside their home health plan service area. For more information, visit **bcbsglobalcore.com**.

Show your Blue Cross member ID card to your doctor or health care provider to verify your PPO benefits.

Choosing the right place for care

We've got you covered with care that's always there. When it's not an emergency, you have smart choices for care that will help you get the care you need, when you need it.

PRIMARY CARE PROVIDER	24-HOUR NURSE LINE	VIRTUAL CARE	WALK-IN CLINICS	
			RETAIL HEALTH CLINIC	URGENT CARE CENTERS
$	$0	$	$-$$	
AVERAGE WAIT TIME FOR CARE 30 minutes	**AVERAGE WAIT TIME FOR CARE** 1 minute	**AVERAGE WAIT TIME FOR CARE** 10 minutes	**AVERAGE WAIT TIME FOR CARE** 30 to 60 minutes	
APPOINTMENT REQUIRED? Yes	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** No	
AVAILABLITY In person By phone Virtually	**AVAILABLITY** By phone	**AVAILABLITY** Virtually through the Teladoc Health® app	**AVAILABLITY** In person	
TREATMENT Start here when you want to talk with a doctor you know and trust	**TREATMENT** When you have questions about an illness or injury, anytime day or night	**TREATMENT** When you want to talk to a doctor or therapist virtually from your mobile device or telephone	**TREATMENT** For a quick, in-person evaluation to get minor health care and a prescription at one location	**TREATMENT** When your symptoms are a little more complicated and you need convenient, in-person care
• High-quality, comprehensive care • Knows you and your medical history and coordinates all your care • Many primary care offices offer virtual care, same-day appointments, extended hours and other services • You may have Virtual Primary Care through Teladoc Health® (for Blue Cross' PPO members*)	• No cost • Available by phone anytime, anywhere in the U.S. • Care provided by a registered nurse	• Video chat 24/7 with a provider or therapist anywhere in the U.S. • Send a visit summary to your primary doctor • Care provided by U.S. board-certified doctors and therapists • Prescriptions, if needed, can be sent to a pharmacy you prefer	• Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board-certified doctor	• Evening and weekend hours • Convenient locations • May offer labs and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms

*Remember to coordinate all your care with your primary care provider. Follow up with him or her after receiving care elsewhere.

Learn about care that's always there at **bcbsm.com/findcare**.

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

Making membership changes

Eligibility, enrollment and membership

You can also verify your Blue Cross membership records on our website when you log in to your account and click *Account Settings*.

Family coverage

Coverage for your family member is based on the certificates and riders included in your health plan. For dependent eligibility criteria, refer to your certificates and riders, which are available online. If you don't have online access, call the Customer Service phone number on the back of your Blue Cross member ID card.

Special enrollment periods

If you decline enrollment for yourself and your family members (including your spouse) because of other health coverage, you may enroll in this health plan later if:

- Your other coverage is terminated because of loss of eligibility or if employer contributions for the other coverage are terminated — provided that you request enrollment within 31 days after your other coverage or the contribution toward that coverage ends.
- You have a new dependent because of marriage, birth, adoption or placement for adoption — provided you request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

Note: Loss of eligibility includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It doesn’t include loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you decline enrollment because you had COBRA continuation coverage under another health plan, you must exhaust your COBRA coverage before you may enroll in this health plan because of a loss of eligibility.

To request a special enrollment or obtain more information, see your Human Resources department.

Promptly report the following changes to your employer. Your employer will notify Blue Cross Blue Shield of Michigan.

- Change of name or address — immediately
- Weddings — within 31 days of marriage
- New babies — within 31 days of birth
- Adoptions — within 31 days of the date of petition or the date of adoption
- Military service — within 30 days of induction or discharge
- 65th birthday — when you or your dependent become eligible for Medicare
- Children — contact your employer to verify eligibility for your children

Continuing coverage on your own

Your coverage will end for you and your family members when you are no longer eligible through your employer group. However, you may continue temporary coverage through COBRA.

Contact your human resources department for your coverage options and to find out eligibility dates.

Claims information

With our extensive network of participating providers and our BlueCard® program, the only time you may have to file your own claims is if you receive services from a nonparticipating or out-of-network provider.

Filing a claim

If you receive services from a nonparticipating or non-network provider, ask the provider if he or she will bill us for the services. Most providers will submit claims to their patients' insurance companies when asked.

If your provider won’t bill us for you, follow these steps:

- Ask the provider for an itemized statement or receipt with the following information:
  - Name and address of provider
  - Full name of patient
  - Date of service
  - Provider's charge
  - Diagnosis and type of service
- Make a copy of all items for your files and send the originals to us with the claim form. It’s important that you file claims promptly because most services have claims filing limitations. To find the form:
  - Visit **bcbsm.com** and log in.
  - Click *Forms*.
  - Select *Reimbursement Forms* under *Claims*.
  - Click on *View a complete list of forms* and select the form option you need to mail your claim.
  - **Note:** If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks or money order stubs may accompany your itemized receipts, but may not substitute for an itemized statement.

Payments for services will be made directly to you.

Explanation of benefits

Your explanation of benefits

After claims processing for services you receive, we send you an explanation of benefits, or EOB. This isn't a bill. It helps you understand how your benefits were paid. At the top of the EOB statement, you'll find phone numbers and our address to use for questions.

Receive your explanation of benefits electronically

Instead of receiving your EOBs in the mail, you can sign up to get them online.

Blue Cross will notify you by email when a new EOB has been posted. Here's how to sign up for electronic statements:

- Visit **bcbsm.com** and log in.
- Click on your name in the upper right corner.
- Select *Paperless Options*.

Reading your EOB

Briefly, your statement includes:

- The person who received the services and the date services were provided
- Claim Summary, which lists the providers of the services, and payments, including the amount saved by using network providers
- Summary of Deductibles and Out-of-Pocket Maximums, which shows your deductible and copayment requirements and a total of all deductibles and copayments paid to date
- Claim Details, which summarizes the Blue Cross payment and shows your balance

If you see an error, contact your provider first. If your provider can't correct the error, call the Customer Service number on your EOB.

What if my claim is rejected?

Our goal is to process your claims correctly every time. If we deny your claim for payment, you can appeal the denial. For more information on the appeals process:

- Visit **bcbsm.com/importantinfo**.
- Click *Resolving problems*.

If, after an internal review, you're still dissatisfied, you have the right to request an independent external review.

EOB

Getting the care you need

Access to our staff

Blue Cross works with our network providers to make sure you're getting the highest-quality care and service, and that you receive it promptly. This is called utilization management. If you have questions or want more information about this process, call the Customer Service number on the back of your member ID card. TTY users, call 711 or call **1-800-696-8350**. You must have a TTY device to use the TTY number.

Evaluating medical technology

Blue Cross Blue Shield of Michigan and Blue Care Network evaluate new technologies and the new applications of existing technologies to develop medical policies and make coverage recommendations. This process includes, but isn’t limited to, medical procedures and services, medical devices, surgical procedures, behavioral health procedures and pharmaceuticals.

Emergency care

If you're not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but think it needs prompt attention, it's best to call your doctor or your doctor's after-hours phone number.

You can also visit a network urgent care center for non-emergency conditions, such as earaches, colds, flu, minor burns, fever, sprains, sore throats and headaches. Visit **bcbsm.com** for a list of urgent care centers.

If you have an emergency and taking the time to call your doctor may mean permanent damage to your health, seek treatment first. Go to the nearest emergency room or call 911.

After the emergency has passed, your doctor can arrange appropriate follow-up care.

Some services aren't in your health plan

Experimental treatment: We don’t pay for experimental treatment. Facility services and physician services, including diagnostic tests related to experimental procedures also aren’t payable. Please refer to your certificate for an explanation on how we determine experimental services. For a list of services not in your health plan:

- Log in at **bcbsm.com**.
- Click *My Coverage*.
- Click *Medical*.
- Click *What's Covered* and scroll down to see what's not included.

Prescription drug coverage

If you have prescription drug coverage, visit **bcbsm.com/pharmacy** for detailed information about what your health plan includes and the best way to use your prescription benefits. You can also find information about:

- Drugs included in our pharmacy health plans
- Mail-order drug forms
- How to get approval for your medications (some drugs need prior authorization or step therapy before your health plan will pay for them)
- Generic drug substitutions
- Quantity limits
- Preferred alternatives
- How to find a pharmacy
- Saving money on prescriptions
- How to request a review for coverage (if a drug isn't included in your health plan)
- Out-of-pocket expenses you pay for prescription drugs:
  - Visit **bcbsm.com** and log in as a member.
  - Click *My Coverage* and select *Prescription*.
  - Click *on view your prescription benefits.*
- Do you need to speak to someone? Visit **bcbsm.com**, click *Contact Us* at the top of the page and follow the instructions.

Coordination of benefits

Coordination of benefits, or COB, is how health plans coordinate benefits when you have more than one health plan. Under COB, health plans work together to make sure you receive the maximum benefits available. Your Blue Cross health plan requires that your benefit payments be coordinated with those from another group health plan for services that may be payable under both health plans.

If Blue Cross isn’t your primary insurer, ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim with the primary carrier's payment statement to Blue Cross.

Updating COB information is your responsibility

You can avoid claims processing delays if you keep your COB information up to date. You can view your current COB information online.

If you need to change the information we have on record, notify your employer immediately. We may also periodically ask you to update your COB information.

For more information, visit **bcbsm.com/cob**.

Subrogation

Your contract with Blue Cross Blue Shield of Michigan includes a provision called "subrogation." If you file a lawsuit or an insurance claim, or if there is a settlement, subrogation allows Blue Cross Blue Shield of Michigan to hold a party that caused an injury or condition to be responsible for payment of the medical expenses related to the injury. For more information or for a copy of the form:

- Login to **bcbsm.com**.
- Click *Forms*.
- Click on *Subrogation Forms* under *Accident or Injury.*
- Fill out the *Subrogation Questionnaire*.

If we ask you to complete this form as the result of a claim, send it to:

Mail: Blue Cross Blue Shield of Michigan
Subrogation Department
232 S. Capitol Ave., L09A
Lansing, MI 48933-1504

Email: SubrogationUnit@bcbsm.com

Phone: **1-866-296-3975**

Fax: **1-877-257-2012**

If you hire an attorney to represent you, have your attorney call Blue Cross at **1-866-296-3975**.

Customer Service

To call us, use the phone number printed on the back of your member ID card. You can also find this number on your EOBs.

Our Customer Service hours are Monday through Friday from 8:30 a.m. to 5 p.m.

Our goal is to provide excellent service. When you call, please be ready to tell us your contract number. If you're inquiring about a claim, we'll also need the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (for example, surgery, office call, X-ray)
- Provider's charges

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. For more information, go to **bcbsm.com/importantinfo**, click on *Privacy practices* to access our *Protected Health Information and Privacy Forms* page.

Language translation services

When you call the Customer Service number on the back of your Blue Cross member ID card, you can request language assistance.

If you have a complaint

Blue Cross Blue Shield of Michigan and your primary care provider are interested in your satisfaction with the services you receive as a member. If you have a problem or concern about your care, we encourage you to discuss this with your primary care provider first. Most of the time, your primary care provider can correct the problem to your satisfaction. You're also welcome to call our Customer Service department with questions or concerns.

At any point during the complaint process, you may submit information or evidence to assist Blue Cross Blue Shield of Michigan in our investigation. You may file a complaint or appeal verbally or in writing. Complaints won't be accepted through email. There are no fees or costs associated with filing a complaint. Submit complaints by calling Customer Service using the phone number on the back of your Blue Cross member ID card, or by mail to:

Blue Cross Blue Shield of Michigan
Complaints — Mail Code 2004
600 E. Lafayette Blvd.
Detroit, MI 48226
Fax: 1-877-348-2210

Members rights and responsibilities

Members have the right to:

- Receive considerate and courteous care with respect for their privacy and human dignity.
- Candidly discuss appropriate, medically necessary treatment options for their health conditions, regardless of cost or benefit coverage.
- Participate with practitioners in decision making regarding their health care.
- Voice concerns or complaints about their health care by contacting Customer Service or submitting a formal written grievance through the Member Grievance program.
- Receive clear and understandable written information about Blue Cross Blue Shield of Michigan, its services, its practitioners and providers, and their rights and responsibilities.
- Make recommendations regarding members' rights and responsibilities policies.

Members have the responsibility to:

- Comply with the health plans and instructions for care they have agreed to with their practitioners.
- Provide, to the extent possible, complete and accurate information that Blue Cross Blue Shield of Michigan and its practitioners and providers need to provide care for them.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with federal civil rights laws and don't discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your member ID card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by mail, fax or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226; phone: **1-888-605-6461**, TTY: **711**; fax: 1-866-559-0578; email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**,* or by mail, phone or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201; phone: **1-800-368-1019**, TTY: **1-800-537-7697**; email: OCRComplaint@hhs.gov. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.*

*Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your member ID card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話。

ܐܢ ܐܲܚܬܘܿܢ، ܝܢ ܚܲܕ ܦܲܪܨܘܿܦܵܐ ܕܡܗܲܝܪܝܼܬܘܿܢ، ܣܢܝܼܩ ܠܗܘܿܢ ܗܲܝܲܪܬܵܐ، ܐܲܚܬܘܿܢ ܐܝܼܬܠܵܘܟ̣ܘܿܢ ܙܕܩܵܐ ܕܡܲܩܒܠܝܼܬܘܿܢ ܗܲܝܲܪܬܵܐ ܘܡܘܼܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܘܟ̣ܘܿܢ ܕܠܵܐ ܡܲܦܩܵܢܵܐ. ܠܡܲܡܠܠܵܐ ܥܲܡ ܚܲܕ ܡܬܲܪܓܡܵܢܵܐ، ܩܪܘܿܢ ܠܡܸܢܝܵܢܵܐ ܕܬܸܫܡܸܫܬܵܐ ܕܥܡܝܼܠܹ̈ܐ ܥܲܠ ܚܲܨܵܐ ܕܟܵܪܛܵܐ ܕܗܲܕܵܡܘܼܬܵܘܟ̣ܘܿܢ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

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

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Blue Cross
Blue Shield
Blue Care Network
of Michigan

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