

MESSA LMS

Medical Plan Coverage



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MESSA LMS – Helpful information

Medicare pays the costs for most of your hospital and medical services but it will not pay for all of them. The MESSA LMS plan helps pay some of the cost Medicare does not pay and extends benefits beyond those Medicare offers.

Health care benefits provided under the MESSA LMS plan are underwritten by Blue Cross Blue Shield of Michigan (BCBSM) and 4 Ever Life.

This booklet is designed to help you understand your coverage.

To view your benefit information and medical claims data, go to www.messa.org to access your member account.

If you prefer to talk with a real person about your specific coverage, call the **MESSA Member Service Center** at **800.336.0013** or **TTY 888.445.5614**.

Occasionally, state or federal law requires changes to medical coverage. When such changes occur, this booklet will be revised and posted at www.messa.org.

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

▼ ▼ ▼ ▼ **TIPS ...** to help us serve you better

- 1** Have your ID card handy so you can provide your enrollee ID/contract number. If you are writing to us, include this information in your correspondence.
- 2** To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, obtain a complete description of the service as well as the diagnosis. *Benefits cannot be guaranteed over the phone.*
- 3** To inquire about a claim, please provide the following: **PATIENT'S NAME, PROVIDER'S NAME** (*such as doctor, hospital or supplier*), **DATE THE PATIENT WAS TREATED, TYPE OF SERVICE** (*for example, office visit*), **CHARGE FOR THE SERVICE.**
- 4** When writing to us, please send copies of your bills, other relevant documents, and any correspondence you have received from us. Make sure you keep your originals.
- 5** Include your daytime telephone number as well as your enrollee ID/contract number on all correspondence.

HOW TO CONTACT US

GIVE US A CALL

MESSA Member Service Center – 800.336.0013 or
TTY 888.445.5614

LET'S TALK IN PERSON

Meet with a member service specialist at our East Lansing office, weekdays 8 a.m. to 5 p.m. Our address is 1475 Kendale Blvd., East Lansing, MI.

LET US CALL YOU

Log in to your member account at www.messa.org and send us a secure message if you'd like a MESSA team member to contact you.

BY MAIL

MESSA
1475 Kendale Blvd. | P.O. Box 2560
East Lansing, MI, 48826-2560

YOUR ID CARD

Your MESSA/BCBSM identification (ID) card is your key to receiving quality health care. Your card will look similar to the one shown here.

The numbers on your personal ID card will be different from the one illustrated.

Enrollee name is the name of the person who holds the contract.

Enrollee ID identifies your records in our files. The alpha prefix preceding the enrollee ID number identifies that you have coverage through MESSA.

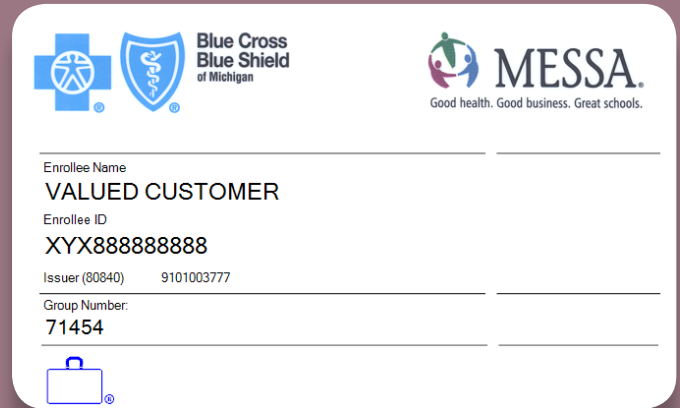
Issuer identifies you as a Blue Cross Blue Shield of Michigan member. The number 80840 identifies the industry as a health insurance carrier.

Group number tells us you are a MESSA/BCBSM group member.

The suitcase tells providers about your travel benefits. On the back of your ID card, you will find:

- A magnetic strip which will help providers process your claims. It includes information from the front of the card and the enrollee's date of birth. It does not include any benefit or health information.
- MESSA's toll-free member services/inquiries telephone number to call us when you have a claim or benefit inquiry, as well as other important telephone numbers.

Your ID card is issued once you enroll for coverage. It lets you obtain services covered under MESSA. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members and dependents.



HERE ARE SOME TIPS ABOUT YOUR ID CARD:

- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you or anyone in your family needs an ID card, you can:
 - Register for or log in to your member account at www.messa.org to request a card (two will be sent per request).
 - Log in to your member account to view and use a virtual ID card.
 - Call the MESSA Member Service Center to request a card.
- Call the MESSA Member Service Center if your card is lost or stolen. You can still receive service by giving the provider your Enrollee ID number to verify your coverage.

ONLY YOU AND YOUR ELIGIBLE DEPENDENTS MAY USE THE CARDS ISSUED FOR YOUR PLAN. LENDING YOUR CARD TO ANYONE NOT ELIGIBLE TO USE IT IS ILLEGAL AND SUBJECT TO POSSIBLE FRAUD INVESTIGATION AND TERMINATION OF COVERAGE.

ELIGIBILITY GUIDELINES

Who is eligible for coverage?

The following individuals are eligible to become members of the Michigan Education Special Services Association (MESSA) and may apply for coverage:

- Any retired member of a bargaining unit that has negotiated MESSA benefits for its members and is enrolled in Medicare Part A and Part B.
- Any retired administrator that was employed by an educational agency that has negotiated MESSA benefits for its members and is enrolled in Medicare Part A and Part B.
- Any retiree eligible for benefits under Section 91 of The

Public School Employees Retirement Act of 1979, being MCLA 38.1391, as amended and who is enrolled in Medicare Part A and Part B.

- Any retired individual otherwise eligible for MESSA benefits as defined in the MESSA bylaws, as amended, and who is enrolled in Medicare Part A and Part B.

Applying for coverage

An application is required if you are:

- Enrolling for the first time.
- Changing coverage for yourself or your dependents.

We will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage based on the terms of your plan.

If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as stated in the section on **When coverage ends**.

NOTE: During the age-in process, any Direct Pay member turning age 65 will automatically be moved into the LMS plan. No application is required for aging-in.

Eligible dependents

If you are covered, your eligible dependents include:

- Your spouse (this does not include the person who marries a member who has coverage as a surviving spouse) enrolled in Medicare Part A and Part B.
- Your children enrolled in Medicare Part A and Part B subject to the following conditions:
 - You continue to be covered under this plan.
 - The children are related to you by birth, marriage, legal adoption or legal guardianship.

NOTE: Your child's spouse and your grandchildren are not covered under this certificate.

- Your sponsored dependents who are enrolled in Medicare Part A and Part B and who are members of your family, either by blood or marriage. They must qualify as

your dependents under the Internal Revenue Code and be declared as dependents on your federal tax return for the preceding tax year. They must be continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

It is your responsibility to notify MESSA:

- When you wish to add a spouse and/or dependent(s).
- Of any change to a dependent's eligibility for coverage.
- When a spouse and/or dependent is no longer eligible as defined above.

When coverage begins

The effective date of coverage for you, your spouse and your eligible dependents will be that date approved by MESSA.

When coverage ends

Your MESSA LMS coverage, and that of your covered dependents, continues until one of the following circumstances occurs:

- **Nonpayment of contributions** – Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.
- **Rescission** – Coverage may be terminated back to the effective date of your coverage if you or someone seeking coverage on your behalf performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of fact to us or another

party which results in you or a dependent obtaining or retaining coverage with MESSA or the payment of claims under this or another MESSA plan. You will be provided with prior notice of the rescission, if required under the law. You will be required to repay us for our payment for any services you received during this period.

- **Member no longer eligible** – Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.
- **Dependent no longer eligible** – Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.

HOW SERVICES ARE PAID

Payment for Medicare Deductible and Coinsurance

We pay the deductible and coinsurance required by Medicare Part A and Part B. Our payments are based on Medicare's approved amount for covered services.

Medicare participating providers and providers that accept assignment are paid directly by Medicare. If a

provider does not participate with Medicare and does not accept assignment, but is considered a payable provider under your MESSA LMS plan, you must pay the provider and then request reimbursement from MESSA.

Services Not Covered by Medicare

There may be cases when Medicare does not pay for a service because you have used up your Medicare benefits or it is not a Medicare benefit.

If a service is not covered by Medicare, but is a benefit under your MESSA LMS plan, we pay the BCBSM approved amount.

Filing Deadlines

All claims must be submitted to MESSA within 24 months of the date of service.

If you have any questions regarding your medical claims, please call MESSA Member Services.

MEDICAL CARE WHILE TRAVELING IN THE U.S.

As a MESSA member, your health coverage goes with you when you travel. You have access to the state and national networks of Blue Cross Blue Shield of Michigan, the underwriter of MESSA medical plans. If you want to keep costs down, it's important to see an in-network doctor. All services are subject to your plan's deductible.

For emergency or accidental injuries:

Call 911 or go to the nearest hospital or emergency room. Emergency care is always covered anywhere within the U.S. Just make sure you have your MESSA/Blue Cross insurance card on you.

For urgent care that requires attention within 48 hours:

All urgent care is covered, no matter where you are. Just make sure you have your MESSA/Blue Cross card with you. **Call 800.336.0013** or **TTY 888.445.5614** or visit **www.messa.org** to find a doctor or hospital.

For non-emergency care:

Find an in-network doctor at **www.messa.org** or **call 800.336.0013** or **TTY 888.445.5614**. When you visit an in-network doctor, you will only pay the rate the local Blue Cross Blue Shield plan negotiated with that doctor for your care. In most cases, you shouldn't have to pay more than what you usually pay for care.

If you see an out-of-network doctor, your share of the costs might go up and you might not be covered for all services.

MEDICAL CARE WHILE TRAVELING OUTSIDE THE U.S.

You have access to doctors and hospitals with the Blue Cross Blue Shield Global Core. You may want to visit the BlueCross Worldwide program’s website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

For emergency care or accidental injuries:

Go to the nearest hospital. Make sure you have your MESSA/Blue Cross card. Emergency and urgent care is covered no matter where you are. If you’re not sure where to go to get help, contact Blue Cross Blue Shield Global Core at **1.800.810.2583** (or call collect at 1.804.673.1177). They can direct you to the nearest medical facility.

You may need to pay for all costs at the time you get care, but we’ll reimburse you for covered medical expenses once you arrive back home. You can submit a claims reimbursement form and send it with any itemized bills to MESSA.

For non-emergency care:

Call Blue Cross Blue Shield Global Core at **1.800.810.2583** to find a hospital or authorized health care provider. You may have to pay for all costs upfront. You can submit a claims reimbursement form for covered medical expenses and send it with any itemized bills to MESSA.

CONTACTING MESSA FROM OUTSIDE THE U.S.

From the U.S. Virgin Islands, Puerto Rico, Canada and Guam: **1.800.380.3251**.

From other foreign countries: **1.517.999.4557**. You will need the United States international access code of the country you are calling from.

ALPHABETICAL LISTING OF SPECIFIC COVERED SERVICES

All services listed below must be medically necessary and performed by a payable provider.

Acupuncture

We pay for acupuncture treatment with an approved diagnosis when performed by an M.D. or D.O. in an inpatient or outpatient hospital setting, ambulatory surgery facility or physician's office.

Allergy services

We pay for diagnostic laboratory tests and allergy therapy, including scratch and/or puncture tests, therapeutic treatments and supplies.

Ambulance

Covered services include transportation by professional ambulance to or from the nearest hospital equipped to furnish treatment. Benefits are also available for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient's transportation is covered. Ambulance transportation is not covered for patient or family convenience or for physician preference.

Anesthesia

Services for giving anesthesia to patients undergoing covered services are payable to either:

- A physician, other than the physician performing the service.
- A physician who orders and supervises anesthesiologist services.
- A certified registered nurse anesthetist (CRNA) in an:
 - Inpatient hospital setting.
 - Outpatient hospital setting.
 - Participating ambulatory surgery facility.

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

If the operating physician gives the anesthesia, the services are included in our payment for the surgery.

Audiologist services

We pay for covered services performed by an audiologist who is licensed or legally qualified to perform these services. To be payable, services performed by an audiologist must be referred by a provider who is legally authorized to prescribe the services.

Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) include Autistic Disorder, Asperger's Disorder and Autism Pervasive Developmental Disorder Not Otherwise Specified.

Applied Behavior Analysis (ABA) is an evidence-based treatment for ASD that is covered under this plan. ABA services are available for children through the age of 18.

Prior authorization of ABA services is required. If prior authorization is not obtained, the member will be responsible for 100% of the cost of treatment.

A member seeking ABA services is required to go to a BCBSM-Approved Autism Evaluation Center (AAEC) for the evaluation, diagnosis and/or confirmation of a diagnosis of an ASD and have a high level treatment plan developed. If ABA services are recommended by the AAEC, the member can seek services from a Board-Certified Behavior Analyst (BCBA), who will then develop a detailed treatment plan specific to ABA treatment. The BCBA **must** obtain prior approval from BCBSM, otherwise the member will be responsible for the cost of treatment.

To be covered, ABA services must be provided or supervised by:

- A Board-Certified Behavior Analyst registered with BCBSM (all BCBA's registered with BCBSM are considered in-network), **or**

- A fully licensed psychologist, so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.

Additional covered services for ASD include:

- Physical Therapy (PT).
- Occupational Therapy (OT).
- Speech Therapy (ST).
- Other medical services used to diagnose and treat autism, including nutrition counseling and genetic testing as recommended by the treatment plan.

Services and conditions not covered:

- Conditions such as Rett’s Disorder and Childhood Disintegrative Disorder.
- Any treatment that is not a covered benefit by us, including, but not limited to, sensory integration therapy and chelation therapy.

Definitions for autism-related services can be found in the Glossary of Health Care Terms of this booklet.

Blood

Medicare does not pay for the first three pints of blood or equal amounts of packed red blood cells you use during a calendar year.

We will pay 100 percent of the approved amount for this blood if it is not replaced in accordance with federal guidelines or is not already paid for under Medicare Part B.

Bone marrow transplants

Preapproval is mandatory. We will not pay for services, admissions or lengths of stay that are not preapproved. Services must be rendered in a designated cancer center. We pay for a maximum of two transplants per member per condition. When medically necessary, and not experimental or investigational, we pay for services for and related to:

- Allogeneic transplants.
- Autologous transplants.

We also pay for antineoplastic drugs or the use of off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Bone marrow transplant – covered conditions

Allogeneic transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients).
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients).
- Acute myelogenous leukemia (high-risk, refractory or relapsed patients).
- Aplastic anemia (acquired or congenital, e.g., Fanconi’s anemia or Diamond-Black fan syndrome).
- Beta-thalassemia.
- Chronic myeloid leukemia.
- Hodgkin’s disease (high-risk, refractory or relapsed patients).
- Myelodysplastic syndromes.
- Neuroblastoma (stage III or IV).
- Non-Hodgkin’s lymphoma (high-risk, refractory or relapsed patients).
- Osteopetrosis.
- Severe combined immune deficiency disease.
- Wiskott-Aldrich syndrome.
- Sickle cell anemia (ss or sc).
- Myelofibrosis.
- Multiple myeloma.
- Primary amyloidosis (AL).
- Glanzmann thrombasthenia.
- Paroxysmal nocturnal hemoglobinuria.
- Kostmann’s syndrome.
- Leukocyte adhesion deficiencies.
- X-linked lymphoproliferative syndrome.
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia).

- Mantle cell lymphoma.
- Congenital leukocyte dysfunction syndromes.
- Congenital pure red cell aplasia.
- Chronic lymphocytic leukemia.
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact.
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact.
- Renal cell CA.
- Plasmacytomas.
- Other conditions for which treatment is non-experimental.

Autologous transplants are covered to treat:

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

- Other conditions for which treatment is non-experimental.

Bone marrow transplant – covered services & exclusions

Allogeneic transplants

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance).
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors.
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
 - A first degree relative and matches at least four of the six important HLA genetic markers with the patient;
 - or**
 - Not a first degree relative but matches five of the six important HLA genetic markers with the patient. (In case of sickle cell anemia (ss or sc) or beta thalassemia, the donor must be an HLA-identical sibling.)

NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a MESSA member.

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

Autologous transplants

- Infusion of colony stimulating growth factors.
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells.
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells.

- High-dose chemotherapy and/or total body irradiation.
- Infusion of bone marrow and/or peripheral blood stem cells.
- Hospitalization.

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma.

We do not pay for:

- Services rendered to a transplant recipient who is not a MESSA member.
- Services rendered to a donor when the donor’s health care coverage will pay.
- Services rendered to a donor when the transplant recipient is not a MESSA member.
- Expenses related to travel or lodging for the donor or recipient.
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements.
- An autologous tandem transplant for any condition other than germ cell tumors of the testes or multiple myeloma.
- An allogeneic tandem transplant.
- Search of an international donor registry.
- 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.
- Any other services or admissions related to any of the above named exclusions.

Chemotherapy drugs

We will pay for covered chemotherapy drugs when billed under your medical plan. LMS only covers medications that would be covered under Medicare Part A and Part B. We will pay our approved amount for drugs:

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

NOTE: If the FDA has not approved the drug for the specific disease being treated, MESSA determines the appropriateness of the drug for that disease by using the following criteria:

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

We pay for:

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

Chiropractic Services

Medicare only pays for manual manipulation of the spine by a chiropractor. We will pay our approved amount for other services of a chiropractor if:

- Medicare would have paid for them if performed by a physician.
- The chiropractor is legally qualified to perform the services.

Cosmetic surgery

Cosmetic surgery is payable for the correction of conditions resulting from an accidental injury or from an illness if the injury or illness was contracted while covered under this plan and only if coverage has been continuous since the date of the accidental injury or the date the illness was contracted.

Dental services

Covered services include dental treatment by a licensed dentist or dental surgeon required for:

- Accidental injury to sound natural teeth.
- The removal of cysts and tumors of the mouth and jaw.
- Extraction of impacted teeth.

An initial mandibular orthopedic repositioning appliance is also covered. Benefits include molding, fitting of and office visits for adjustments to the appliance. Repair or replacement of the appliance is not covered.

Diagnostic services

We pay for diagnostic X-rays, isotopes and ultrasounds required in the diagnosis of an illness, pregnancy or injury. CAT scans and magnetic resonance imaging (MRI) are also payable when medically necessary.

Diagnostic laboratory and pathology services

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury.

Durable Medical Equipment (DME)

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician and purchased from a recognized DME provider. Call MESSA for more information. Benefits include items such as hospital beds and/or wheelchairs. Items such as air purifiers, air conditioners and exercise equipment are not covered.

Emergency care

We pay for facility services and physician charges for the initial exam and treatment in a hospital emergency room or urgent care center. This includes treatment for both accidental injuries and medical emergencies.

Home health care

This program provides an alternative to long-term hospital care by offering coverage for care and services

in the patient's home. Services must be prescribed by the patient's attending physician, be medically necessary and be provided by a home health care agency.

To qualify for this benefit, a covered person must have physician certification assuring home health care is a medically necessary alternative to hospital confinement. We pay the Medicare deductible and coinsurance for services provided by a Medicare home health agency. The services are available based on a 30-day benefit period. The benefit period may be renewed with certification from your physician.

Covered services include:

- Part-time skilled nursing care (full-time care is not covered) rendered by a registered nurse or a licensed practical nurse.
- Medical care rendered by a home health aide or nurse's assistant under the direct supervision of a registered nurse.
- Medical supplies other than drugs and medicines requiring a written prescription from a physician.
- Purchase or rental of medical equipment (not to exceed purchase price).
- Physical therapy, occupational therapy, speech therapy, social service guidance, and nutritional guidance provided by a Medicare-approved home health care agency.
- Hospital services and supplies related to the injury or illness which required or would have required the hospital confinement and would normally be provided by the hospital.

NOTE: Meals, general housekeeping services and custodial care are not covered.

Hospital care

We pay for inpatient and outpatient hospital benefits that are medically necessary and provided by a payable provider.

Medicare Part A inpatient hospital coinsurance and deductible

Medicare Part A helps pay for 90 inpatient hospital days in a Medicare benefit period, plus 60 lifetime reserve days. However, for each benefit period, Medicare requires you to pay a deductible and coinsurance related to any inpatient hospital services.

We pay the deductible for the first to the 60th day of care in any Medicare benefit period.

We pay the coinsurance for the:

- 61st to 90th day of care in any Medicare benefit period.
- 91st through 150th Medicare lifetime reserve days.

Additional Days of Inpatient Hospital Care

We pay for reasonable and necessary inpatient care during a Medicare benefit period if you have used all of the inpatient hospital days covered by Medicare.

Medicare Part B Coinsurance and Deductible

We pay the Medicare deductible and coinsurance for services provided on an inpatient or outpatient basis by a Medicare hospital. Such services include:

- Purchase or rental of durable medical equipment.
- Outpatient physical therapy and speech therapy services provided in a Medicare-approved facility.

Hospice care

Hospice benefits allow covered terminally ill patients to spend their final days at home or in a special hospice facility as approved by MESSA. You may apply for hospice benefits after discussion with, and with a referral by, your attending physician. Benefits become available when:

- The covered patient is terminally ill with a life expectancy of 12 months or less as certified in writing by the attending physician **or**
- You are a covered dependent of the terminally ill patient meeting the requirements described above.

Hospice care services are payable for four 90-day periods. The following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- The following certifications are submitted to us:
 - **First 90-day period** – A written certification stating that the patient is terminally ill, signed by the Medical Director of the hospice program **or** Physician of the hospice interdisciplinary group and attending physician, if the patient has one.
 - **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 Medical Director of the hospice **or** Physician of the hospice interdisciplinary group.
 - **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 Medical Director of the hospice **or** Physician of the hospice interdisciplinary group.
 - **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 Medical Director of the hospice **or** Physician of the hospice interdisciplinary group.

The patient, or his or her representative, must sign a “Waiver of Benefits” form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient’s (or family’s) understanding that regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

NOTE: Our benefits for conditions not related to the terminal illness remain in effect.

Payable services

Before electing to use hospice care services, the patient and his or her family are eligible to receive counseling, evaluation, education and support services from the hospice staff. These services are limited to a 28-visit maximum.

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

- Inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program.
- Occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home.
- Part-time skilled nursing care (full-time care is not included) by a registered nurse or licensed practical nurse.
- Medical supplies.
- Rental of medical equipment (not to exceed purchase price).
- Physical therapy, emotional support services, homemaker or home health aide services (provided by or on behalf of the hospice program).
- Charges for physician services.
- Bereavement counseling for the family after the patient's death. This bereavement counseling benefit ends:
 - 12 months after the date of the first family unit counseling session **or**
 - 18 months after the date the hospice benefit began.

Human organ transplants

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

Benefit period

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

When performed in a designated facility, we pay for transplantation of the following organs:

- Combined small intestine-liver.
- Heart.
- Heart/lung(s).
- Liver.

- Lobar lung.
- Lung(s).
- Pancreas.
- Partial liver.
- Kidney-liver.
- Simultaneous pancreas-kidney.
- Small intestine (small bowel).
- Multivisceral transplants (as determined by MESSA).

Other transplant-related coverage

When directly related to the transplant, we pay for:

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunizations Practices (ACIP). This also includes kidney transplants, but not cornea or skin.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
 - Occurs **during** the benefit period **and**
 - Is a **direct** result of the organ transplant surgery.
- Reimbursement up to \$10,000 for eligible travel and lodging expenses during the initial transplant surgery, which includes:
 - 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) **and**
 - Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient.

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

Limitations and Exclusions

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

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

Human organ transplants (kidney, cornea and skin)

Services for kidney, cornea and skin transplants are covered as standard benefits and are not limited to specific transplant facilities. Living donor and recipient services are paid under the recipient's coverage. To be payable, the recipient must be a MESSA member. We pay for services performed to obtain, test, store and transplant the organs.

Maternity care

You have coverage for prenatal and postnatal care and obstetrical services including delivery. We also pay for newborn nursery care during the mother's stay in a participating hospital for covered maternity care. Maternity care benefits also are payable when provided by a certified nurse midwife at a BCBSM-approved birth center.

Medical supplies

We pay for many medical supplies and dressings when prescribed by a physician. Covered items include:

- Ostomy supplies.
- Needles and syringes.
- Compression or anti-embolism stockings when prescribed for vascular conditions (limited to two pairs per calendar year).
- Surgical brassieres following a mastectomy (limited to three per calendar year).
- Medically necessary supplies to treat and manage diabetes, including but not limited to:
 - Test strips for glucose monitors.
 - Visual reading and urine strip tests.
 - Lancets.
 - Spring-powered lancet devices.

Mental health and substance use disorder services

We pay for mental health and substance use disorder services that are medically necessary and provided by an eligible provider.

Oncology clinical trials

Preapproval is mandatory. We will not pay for services, admissions or lengths of stay that are not preapproved. Preapproval is good only for one year after it is issued.

We pay for a maximum of two single transplants per member for the same condition.

We cover specified bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast

cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. Coverage of antineoplastic drugs is not limited or precluded when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered. Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

Covered services:

● AUTOLOGOUS TRANSPLANTS

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

● ALLOGENEIC TRANSPLANTS

- Blood tests to evaluate donors (if the tests are not covered by their insurance).
- A 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.
- Infusion of colony stimulating growth factors.
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cells and/or umbilical cord Blood.
NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of the harvested material is a MESSA member.
- High-dose chemotherapy and/or total body irradiation.
- T-cell depleted infusion.
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood.
- Donor lymphocyte infusion.
- Hospitalization.

● TRAVEL AND LODGING

- We will pay up to a total of \$5,000 for travel and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.
- We will pay the expenses of an adult patient and another person, or expenses of a patient under the age of 18 and expenses for two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:
 - \$60 per day for travel.
 - \$50 per day for lodging.

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

● ROUTINE PATIENT COSTS

- We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual as defined herein.
- We pay for 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.

We do not pay for:

- The experimental or investigational item, device or service itself.
- 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.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Harvesting and storage costs of bone marrow, umbilical cord blood and/or peripheral blood stem cells if not intended for transplant within one year.

- Services for a transplant recipient who is not a MESSA member.
- Services rendered to a donor when the transplant recipient is not a MESSA member.
- Services rendered to a donor when the donor’s health care coverage will pay.
- Non-health care related services and/or research management (such as administrative costs).
- Search of an international donor registry.
- Items that are not considered directly related to travel and lodging (*examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitter or day care services, services provided by family members, reimbursement of food stamps, mail or UPS services, internet connection, and entertainment (such as cable television, books, magazines and movie rentals)*).
- Any facility, physician or associated services related to any of the above named exclusions .

Preventive care services

We pay for immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or other sources as recognized by BCBSM.

We pay for BRCA (counseling about genetic testing) for women at higher risk.

Preventive screening for cancer is covered and is subject to the following limitations:

- **PROSTATE**
 - Prostate examinations are covered according to the age and frequency limits. This examination is done by a physician during an office visit.
- **BREAST**
 - One breast examination and one screening mammogram per member per calendar year.

- **UTERUS**
 - One pelvic examination and one pap smear per calendar year.
- **COLON AND RECTUM**
 - Digital rectal and proctosigmoidoscopy examinations are covered according to the age and frequency limits.

Private duty nursing

We pay for private duty nursing services performed by either a registered nurse or licensed practical nurse.

Prosthetic and orthotic devices

We pay for prosthetic and orthotic devices when required because you do not have a certain body part or the device would improve your body’s function.

Devices must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or growth.

Benefits include, but are not limited to:

- External breast prostheses following a mastectomy.
- Artificial eyes, ears, nose, larynx, limbs.
- Orthopedic shoes meeting MESSA guidelines.
- Eyeglasses and hearing aids when required because of an accidental injury sustained while covered by this plan.
- One pair of prescription eyeglasses or contact lenses because of cataract surgery performed while covered by this plan or the absence of an organic lens.
- Prefabricated custom-made orthotic appliances.

Psychiatric residential treatment

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

We pay for the following:

- Services provided by facility staff.
- Individual psychotherapeutic treatment.
- Family counseling for members of a patient’s family.
- Group psychotherapeutic treatment.
- Prescribed drugs given by the facility in connection

with the member's treatment plan. LMS only covers medications that would be covered under Medicare Part A and Part B.

Limitations and exclusions

We do not pay for:

- Staff consultations required by a facility's or program's rules.
- Marital counseling.
- Services that are not focused on improving the member's functioning.
- Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program.
- A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community.
- A residential program that serves to protect family members and other individuals in the member's living environment.
- Services or treatment that are cognitive in nature or supplies related to such services or treatment.
- Services, treatment or supplies that are court-ordered or related to a court order.
- Transitional living centers such as half-way and three-quarter-way houses.
- Therapeutic boarding schools.
- Milieu therapies, such as wilderness programs, supportive houses or group homes.
- Domiciliary foster care.
- Custodial care.
- Treatment or programs for sex offenders or perpetrators of sexual or physical violence.
- Services to hold or confine a member under chemical influence when the member does not require medical treatment.
- A private room or apartment.
- 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, and

educational or preparatory courses or classes. These services may be paid as part of a treatment program, but they are not payable separately.

Radiology services

Diagnostic – We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-ray.
- Ultrasound.
- Radioactive isotopes.
- Computerized Axial Tomography.

Magnetic Resonance Imaging for specific diagnoses
(you should call MESSA for information about any restrictions)

Skilled nursing care

A skilled nursing facility provides comprehensive inpatient care of either a short or extended duration and is operated under the general direction of a licensed physician. A skilled nursing admission must occur within 14 days of at least a three-day hospital confinement for the same condition or your doctor must certify that admission into a skilled nursing facility is a medically necessary alternative to hospital confinement. **This benefit does not include custodial or domiciliary care.**

After a related three-day inpatient hospital stay, Medicare Part A pays for care in a Medicare-approved skilled nursing facility for up to 100 days in a Medicare benefit period. Medicare requires you to pay coinsurance for the 21st through the 100th day of care. We pay the coinsurance only if Medicare covers the skilled nursing facility stay.

We also pay the Medicare deductible and coinsurance for services provided by a Medicare skilled nursing facility. Such services include:

- Purchase or rental of durable medical equipment.
- Outpatient physical therapy and speech therapy services provided in a Medicare-approved facility.

Surgical services

We pay for surgical procedures determined to be medically necessary and performed by a licensed physician.

Multiple surgeries

When multiple surgeries are performed on the same day by the same physician, payment is as follows:

- Multiple surgeries through the same incision by the same physician are considered related; therefore, we will pay our approved amount of the more difficult procedure.
- Multiple surgeries through different incisions by the same physician are paid as follows:
 - Our approved amount for the more costly procedure **and**
 - 50% of the approved amount for the less costly procedure(s).

NOTE: Determination of the more or less difficult procedure is based on the approved amount.

Restrictions

Dental surgery is payable only for the removal of cysts and tumors of the mouth and jaw and the extraction of impacted teeth.

Technical surgical assistance

We pay for technical surgical assistance provided by a licensed physician for surgical procedures as determined by MESSA.

Therapy services

Therapy services are paid if obtained in the outpatient department of a hospital, doctor's office, freestanding facility or by an independent physical therapist.

Therapy must be medically necessary and ordered by, and performed under, the supervision or direction of a legally qualified physician except where noted.

Outpatient benefits include the following:

● OCCUPATIONAL THERAPY

(Services must be performed by):

- A doctor of medicine or osteopathy.
- An occupational therapist.
- An occupational therapy assistant under the direct supervision of an occupational therapist.
- An athletic trainer under the direct supervision of an occupational therapist.

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

● PHYSICAL THERAPY

(Services must be performed by):

- A doctor of medicine, osteopathy or podiatry.
- A licensed physical therapist.
- A physical therapy assistant under the direct supervision of a licensed physical therapist.
- An athletic trainer under the direct supervision of a licensed physical therapist.
- Therapy must be designed to improve or restore the patient's functional level when there has been a loss in musculoskeletal functioning due to an illness or injury.

● SPEECH THERAPY

(Services must be performed by):

- A doctor of medicine or osteopathy.
- A licensed speech-language pathologist.
- We do not pay for services provided by speech-language pathology assistants or therapy aides.
- For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

Voluntary sterilization

Services are covered for voluntary sterilization for both males and females. Reversal of sterilization procedures is not covered.

Weight loss management

We pay for services performed by a qualified physician for the treatment of morbid obesity. To qualify for this benefit, you must be one and one-half times the recommended normal weight. For this condition, a special benefit period begins with the date of the first service and ends three years following that date.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to the MESSA LMS program. These are in addition to limitations appearing elsewhere in this booklet.

- Prescription medications.
NOTE: LMS only covers medications that would be covered under Medicare Part A and Part B.
- Artificial insemination (including in vitro fertilization) and related services.
- A provider's charge in excess of Medicare's approved amount.
- A provider's charge in excess of our approved amount for emergency care received outside the United States.
- Care for conditions connected with employment with any employer.
- Charges incurred because of war, declared or undeclared, or any act thereof.
- Injury or sickness sustained or contracted in the armed forces or any country.
- Services provided in a Veterans Administration Hospital for a covered person with military service-connected disability.
- Services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without cost in the absence of this coverage or for which the covered person has no legal obligation to pay.
NOTE: Federal laws may require a government-sponsored program to be secondary. If so, we pay for care and services.
- Clerical fees including fees for patient records.
- Custodial care or basic care that can be provided by someone other than a registered nurse or licensed practical nurse.
- Dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances and other dental work or treatment.
- Drugs or devices not approved by the Food and Drug Administration (FDA).
- Educational care and cognitive therapy.
- Experimental treatment (including experimental drugs or devices) or services related to experimental treatment except as provided by the BCBSM or MESSA medical director. In addition, we do not pay for administrative costs related to experimental treatment or for research management.
- Eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this booklet.
- Hearing aids (except as previously specified).
- Inpatient hospital confinement for the sole testing for, or detoxification of, allergy or allergy-related conditions.
- Items for the personal comfort or convenience of the patient.
- Prosthetic devices (other than previously specified).
- Radial keratotomy and related services.
- Reversal of sterilization procedures and related services.
- Routine health examinations and related services or routine screening procedures (except as previously specified).
- Services, supplies, or treatment provided by an immediate relative or by anyone who customarily lives in the member's household.
- Services and supplies that are not medically necessary according to accepted standards of medical practice including any services which are experimental or investigational in nature.
- Services you receive if your admission begins before your coverage under this contract is effective.
- Services, treatments, or care provided after the coverage termination date, except hospital inpatient services for an admission that began before the termination date.
- Services that you could get free if you did not have health care coverage.

- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.
- Surgery for cosmetic or beautifying purposes, except for the correction of conditions resulting from an accidental injury or from an illness.
- Treatment related to weight loss (other than previously specified).
- Transplants (other than previously specified) and all charges arising out of or associated with these transplants whether incurred prior to the transplant, at the time of the transplant or subsequently.
- Transportation expenses (except as previously specified) including meals and lodging.
- Drugs or devices provided to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the member's condition, unless the drugs or devices are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drugs or devices.

GRIEVANCE PROCESS

MESSA wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact our Member Service Center at 800.336.0013 or TTY 888.445.5614.

Grievance process

MESSA wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact our Member Service Center at 800.336.0013 or TTY 888.445.5614.

Eligibility grievance process

You or your authorized representative may send us a written statement explaining why you disagree with our decision regarding your eligibility or rescission of your coverage. Your request for review must be submitted within 180 days after receiving a notice of denial. Mail your written grievance to:

Associate Manager, Legal and Compliance MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

We have 60 days to give you our final determination. You have the right to allow us additional time if you wish.

A decision will be made by MESSA after we receive your request for review or the date you provide all information required of you, whichever date is later. The decision will be in writing and will specify the reason for MESSA's decision.

If you disagree with our final decision, or you do not receive our decision within 60 days, you may request an external review. See below for how to request an external review.

Grievance and appeals process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of

your coverage. An adverse benefit decision includes a:

- Denial of a request for benefits
 - A utilization review revealed the benefit should not have been paid.
 - We determined the service to be experimental, investigational, or not medically necessary or appropriate.
- Reduction in benefits.
- Failure to pay for a service, **or**
- Failure to respond in a timely manner to a request for a determination.

You may file a grievance or appeal about any adverse benefit decision within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges.
- You may submit materials or testimony at any step of the process to help us in our review.
- 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 MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614 and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- You do not have to pay for copies of information relating to MESSA/BCBSM's decision to deny, reduce or terminate or cancel your coverage.

The grievance and appeals process begins with an internal review by MESSA and BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

NOTE: You do not have to exhaust our internal grievance

process before requesting an external review in certain circumstances:

- We waive the requirement.
- We fail to comply with our internal grievance process.
 - » Our failure to comply must be for more than minor violations of the internal grievance process. Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Grievance Process

Step 1: You or your authorized representative send us a written statement explaining why you disagree with our decision. Your request for review must be submitted within 180 days after receiving a notice of denial. Mail your written grievance to:

Associate Manager, Legal and Compliance MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

For pre-service appeals, we have 15 days to give you our final determination.

For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

A decision will be made by MESSA/BCBSM after MESSA receives your request for review or the date you provide all information required of you, whichever date is later.

The decision will be in writing and will specify the reason for MESSA/BCBSM’s decision.

Step 2: If you are dissatisfied with this decision, you may request a managerial-level conference by calling the MESSA Legal and Compliance Department at 800.742.2328 or mailing your written request to:

Associate Manager, Legal and Compliance MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

During your conference, you can provide us with any other information you want us 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 the MESSA/BCBSM headquarters in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

For pre-service appeals, we have 15 days to give you our final determination.

For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

BCBSM and MESSA will complete both steps within 30 days of the date we receive your written grievance under Step 1 for pre-service appeals, and within 60 days for post-service appeals. These time periods do not include the time between your receiving our decision under Step 1 and requesting further review under Step 2.

If you disagree with our final decision, or you do not receive our decision within 30 days after we received your original grievance for a pre-service appeal, or within 60 days for a post-service appeal, you may request an external review. See below for how to request an external review.

Standard External Review Process

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

Within 120 days of the date you receive or should have received our final decision, send a written request for an

external review to the Department listed below. Mail your request and the required forms that we give you to:

**Department of Insurance and Financial Services Office
of General Counsel**

Health Care Appeals Section

P.O. Box 30220

Lansing, MI 48909-7720

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.

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 group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and MESSA/BCBSM if the Department decides to accept the group's recommendation. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Review of Medical Issues

The Department will assign an independent review group 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 business days of requesting an external review. We must give the independent review group all of the information we considered when we made a final decision, within seven business days of getting notice of your request from the Department.

The review group will recommend within 14 days whether the Department should uphold or reverse our 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.

Review of Nonmedical Issues

If your request for an external review is related to nonmedical issues and is appropriate for external review, Department staff will recommend whether our determination should be upheld or reversed.

The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

You may file an expedited internal review request if your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:

- Your life or health, **or**
- Your ability to regain maximum function

To submit a request for an expedited internal review, **call 800.742.2328, option 4, or TTY 888.445.5614.** Your physician must also call this number to confirm that you qualify for an expedited review.

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

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Department of Insurance and Financial Services.

If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review. For more information on how to ask for an urgent review or simultaneous expedited external review, call the **MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614.**

Expedited External Review Process

If you have filed a request for an expedited internal grievance, you may concurrently request an expedited external review from the Michigan Department of Insurance and Financial Services. Otherwise, the process is as follows:

- A request for external review form will be sent to you or your representative with our final adverse determination.
- Within 10 days of receiving your denial, complete this form 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.**

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.

- The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.
- 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.

NEED MORE INFORMATION?

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we 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 customer service number on the back of your identification card.

For questions about your rights, this notice, or for assistance, you can contact the **MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614.** You can also contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

TO CONTACT THE DIRECTOR:

Call toll-free at 1.877.999.6442; or mail to:
Department of Insurance and Financial Services
P.O. Box 30220 | Lansing, MI 48909-7720

OTHER GENERAL INFORMATION

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Contest

If you seek payment for a denied claim, MESSA will furnish you with specific reason(s) for the denial, as well as any additional information required. If you ask us to reconsider the claim under our claim review procedure and we maintain our denial, you must wait 30 days before bringing any legal action against us. If the claim is two years old or more, you cannot bring any legal action against us.

Coordination of benefits

We will coordinate benefits payable under this plan pursuant to the Michigan's Coordination of Benefits Act (starting at MCLA 550.251). Coordination of benefits is used when you are eligible for payment under more than one group insurance plan. This provision ensures that your covered expenses will be paid. The combined payments will not exceed the actual cost, nor the amount that you would have paid.

We do not pay any cost-sharing that you must pay under any other certificate, subject to coordination of benefit requirements.

Determination of medical necessity

There may be instances when benefit restrictions may be waived for in-network services. When medically appropriate, personal care physicians and/or network managers may obtain authorization for covered services beyond our normal payment rules.

Subrogation: when others are responsible for illness or injury

If MESSA/BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, **or**
- You are entitled to receive money for the illness or injury

Then MESSA/BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is MESSA/BCBSM's right of recovery. MESSA/BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. MESSA/BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

Whether you are represented by an attorney or not, this provision applies to:

- You.
- Your covered dependents.

You agree to:

- Cooperate and do what is reasonably necessary to assist MESSA/BCBSM in the pursuit of its right of recovery.
- Not take action that may prejudice MESSA/BCBSM's right of recovery.
- Permit MESSA/BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact MESSA/BCBSM promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.

MESSA/BCBSM may:

- Seek a first priority lien on proceeds of your claim in order to fulfill MESSA/BCBSM's right of recovery.
- Request you to sign a reimbursement agreement.
- Delay processing of your claims until you provide a signed copy of the reimbursement agreement.
- Offset future benefits to enforce MESSA/BCBSM's right of recovery.

MESSA/BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made.

- Recover money it paid on your behalf if another person or insurance company is responsible:
 - When a third party injures you, for example, through medical malpractice;
 - When you are injured on premises owned by a third party; **or**
 - 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.

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.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Services before coverage begins or after coverage ends

Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, our payment will be based on the facility’s contract with BCBSM. Our payment may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**
- The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your MESSA coverage or after it ends.

Member liability

Certain technical enhancements, which may improve the safety or comfort of a procedure, may involve additional

costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered. The provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Time limit for legal action

Legal action against us may not begin later than three years after we have received a complete claim for services. No action or lawsuit may be started until 60 days after you notify us that our decision under the claim review procedure is unacceptable.

What laws apply

This contract is subject to and interpreted under the laws of the state of Michigan.

Accidental injury

Any physical damage caused by an action, object or substance outside the body, such as:

- Strains, sprains, cuts and bruises.
- Allergic reactions caused by an outside force such as bee stings or other insect bites.
- Extreme frostbite, sunburn, sunstroke.
- Swallowing poisons.
- Drug overdosing.
- Inhaling smoke, carbon monoxide or fumes.

Acute care

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

Administrative costs (approved oncology trials)

Costs incurred by the organization sponsoring the 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.

Allogeneic (allogenic) bone marrow transplant

A procedure using another person’s bone marrow or peripheral blood stem cells to transplant into the patient. This includes syngeneic transplants (when the donor is the identical twin of the patient).

Ambulance service

Is transportation and life support services furnished to sick, injured or incapacitated patients by a licensed ambulance operation by means of ambulance vehicles or air ambulance and personnel recognized as qualified to perform such services at the time and place where rendered.

Approved amount

The lower of the billed charge or our maximum payment

level for the covered service. Deductibles, copayments and/or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved clinical trial

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 federally funded trial, as described in the Patient Protection and Affordable Care Act (PPACA).
- A trial conducted under an investigational new drug application reviewed by the FDA.
- A drug trial that is exempt from having an investigational new drug application.
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the PPACA.

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

- **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 commissioner of the Department of Insurance and Financial Regulation, if the commissioner 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:
 - Evaluate and diagnose the member as having one of the covered autism spectrum disorders **and**

- Recommend an initial high-level treatment plan for members with autism spectrum disorders.
- **AUTISM SPECTRUM DISORDERS** This includes 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.
- **BEHAVIORAL HEALTH TREATMENT** Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both the following requirements:
 - Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
 - 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.
- **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.
- **BOARD CERTIFIED BEHAVIOR ANALYST** An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

NOTE: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.
- **AUTISM 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.
- **AUTISM PRIOR AUTHORIZATION PROCESS** A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/ representative) approves all applied behavioral analysis services. A request for continued services will be authorized contingent on the member

meeting mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at 3, 6, or 9 month intervals or at other mutually agreed upon intervals after the onset of treatment.

- **AUTISM TREATMENT PLAN** 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 3, 6 and/or 9 months or at mutually agreed upon intervals. There are two levels to the treatment plan:
 - The approved autism evaluation center will recommend an initial high-level treatment plan.
 - The board certified behavior analyst will develop a detailed treatment plan specific to applied behavioral analysis treatment.

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.

Certified nurse midwife

A nurse who provides some maternity services and who:

- Is licensed as a registered nurse by the state of Michigan.
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing.
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing.
- Participates with BCBSM.

Certified registered nurse anesthetist

A nurse who provides anesthesiology services and who:

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

Claim for damages

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

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:

- **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.
- **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.

Coinsurance

A part of the Medicare approved amount Medicare requires you to pay after you have met your deductible. (We pay this amount for you.) Your coinsurance is not altered by any 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.

Contraception

Birth control drugs, devices (such as but not limited to diaphragms, IUDs, and contraceptive implants) and injections designed to prevent pregnancy.

Contract

The insurance certificate and related riders, your signed application for coverage and your MESSA/BCBSM ID card.

Conventional treatment

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

Copayment

The flat dollar amount that you must pay for a covered service.

Covered services

The services, treatments or supplies identified as payable in your certificate. Such services must be medically necessary, as defined in this booklet, 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, or eligible, as determined by us, to order or perform the service and must comply with our policies when rendering 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, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible

The amount Medicare requires of you before benefits are paid. (We pay this amount for you.)

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.

Direct supervision

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

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. This date is established by us.

Emergency care

Is care needed immediately because of an injury or an illness which occurred suddenly and unexpectedly.

Emergency medical condition

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

- The health of the patient (or with respect to a pregnant woman, the health of the woman and her unborn child) to be in serious jeopardy, **or**
- Serious impairment to bodily functions, **or**
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or the 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.

Exclusions

Situations, conditions, or services that are not covered by the subscriber’s contract.

Experimental or investigational treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient’s condition as conventional treatment. Sometimes it is referred to as “experimental services.”

First degree relative

An immediate family member who is directly related to the patient; either 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:

- Judgment or settlement of a legal action.
- Settlement not due to legal action.
- Undisputed payment.

This right may be invoked without regard for:

- Whether plaintiff’s recovery is partial or complete.
- Who holds the recovery.
- Where the recovery is held.

Food and Drug Administration (FDA)

An agency with 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.

Freestanding outpatient physical therapy facility

An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy

services and functional occupational therapy or speech and language pathology services.

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.

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

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.

Independent physical therapist

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

- Is licensed as a physical therapist by the state of Michigan.
- Meets our qualification standards.
- 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 we paid as a result of the plaintiff's injuries.

Life threatening condition

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

Life threatening medical emergency

Is a health threatening or disabling condition which is not the result of accidental injury and which requires immediate medical attention and treatment. The condition is of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the member's health, or place the member's life in jeopardy. The member's signs and symptoms at the time of treatment, verified by the treating physician, must confirm the existence of a threat to the patient's life or bodily functions.

Lifetime reserve days

Are an extra 60 inpatient hospital days covered by Medicare, which cannot be renewed.

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.

Medically necessary

A service must be **medically necessary** to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and Long Term Acute Care Hospitals (LTACHs); and a third applies to other providers.

Medical necessity for payment of professional 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:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease **and**
- Not primarily for the convenience of the member, professional provider, or other 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.

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

Medicare

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

Medicare approved amount

Is the portion of the provider’s charge approved by Medicare as payable. The charge includes the Medicare Part A or Medicare Part B payment level and deductible and/or coinsurance amounts.

Medicare benefit period (Spell of Illness)

Is a period of consecutive days that begins the day the patient is admitted as an inpatient in a hospital or skilled nursing facility (SNF). The benefit period ends when the patient has not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If the patient goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Medicare eligible expenses

Are health care costs which are recognized as reasonable and necessary by Medicare.

Medicare home health agency

Is a home health care agency which has a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare’s approved amount as payment in full for covered services.

Medicare participating hospital

Is a hospital which has a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare’s approved amount as payment in full for covered services.

Medicare participating provider

Is a provider who has signed a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare’s approved amount as payment in full for covered services.

Medicare skilled nursing facility

Is a skilled nursing facility which has a contract with the federal government to provide care to patients enrolled in the Medicare Program. The facility agrees to accept Medicare’s approved amount as payment in full.

Member

An individual who is a member of MESSA. For purposes of benefits under this plan, “member” includes you and your covered dependents.

MESSA

Michigan Education Special Services Association.

Nonparticipating hospital

A hospital that has not signed a participation agreement with BCBSM or another Blue Cross plan to accept the approved amount as payment in full.

Nonparticipating provider

Physicians or other health care professionals who have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational therapy

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

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

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.

Orthopedic shoes

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 services

Services available to member living or traveling outside a health plan’s service area.

Out-of-network provider

Hospitals, physicians and other licensed facilities or health care professionals who have not contracted to provide services to members enrolled in MESSA LMS.

Outpatient psychiatric facility

A licensed facility providing outpatient mental health services. It includes centers for mental health care such as hospitals, clinics, day treatment centers and community mental health centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

Outpatient substance abuse treatment program

A program that provides medical and other services specifically for drug and alcohol abuse on an outpatient basis.

Participating hospital

A hospital that has 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 we make our payment.

Participating providers

Physicians or other health care professionals who 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 we make our payment.

Patient

The subscriber or eligible dependent who is awaiting or receiving medical care and treatment.

Peripheral blood stem cell transplant

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

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, stem cells).

Physical therapy

The use of specific activities or methods to treat a disability when there is a loss of neuro-musculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient’s specific muscles or joints to restore or improve:

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

Physician

A physician is a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, oral surgeon dentist, podiatrist, doctor of chiropractic or other provider identified by us who is legally qualified and licensed to practice at the time and place services are performed is deemed to be a physician to the extent that the doctor renders services which he/ she is legally qualified to perform.

A physician is also a person who is licensed under Act 368 Public Acts of Michigan 1978, as a fully licensed psychologist at the time services are performed. In a state where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Physicians may also be referred to as “practitioners.”

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.

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 or oral surgeon) or other professional provider who participates with BCBSM or who is an in-network provider. Practitioner may also be referred to as “participating” or “panel” or “in-network” provider.

Primary payer

The health care coverage plan that pays first when you are provided benefits by more than one carrier.

Professional provider

This refers to one of the following:

- Doctor of medicine (M.D.) Clinical licensed master’s social worker.
- Doctor of osteopathy (D.O.) Licensed professional counselor (LPC).
- Podiatrist Oral surgeon.
- Chiropractor Board certified behavior analyst.
- Physician assistant (PA).
- Licensed marriage and family therapist (LMFT).
- Fully licensed psychologist Other providers as identified by BCBSM.
- Limited license psychologist (LLP).

NOTE: Professional providers may also be referred to as “practitioners.”

Prosthetic device

An artificial appliance that:

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

Provider

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

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 individual

An individual eligible for coverage 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:

- The referring provider participates in the trial and has concluded that the individual's participation in the trial would be appropriate because the individual meets the trial's protocol, **or**
- 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.

Refractory patient

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

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.

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 program is sometimes called "intermediate care."

Right of reimbursement

Our right 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 us.

Routine patient costs

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:

- The investigational item, device or service itself.
- 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**
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Service area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE: 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 disease, injury, condition or pregnancy.

Skilled nursing facilities

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

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.

Stem cells

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

Subrogation

Our assumption of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Substance abuse

Taking alcohol or other drugs in amounts that can:

- Harm a person’s physical, mental, social and economic well-being.
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior.
- Endanger the safety or welfare of 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.”

NOTE: Tobacco addictions are included in this definition.

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.

Terminally ill

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

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.

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.

We, us, our

Used when referring to Blue Cross Blue Shield of Michigan or MESSA.

You and your

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

MESSA LMS

Medical Plan Coverage



MESSASM

1475 Kendale Boulevard, P.O. Box 2560, East Lansing, MI 48826-2560

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