

Super Care 1
2003 Revision
Plan Coverage Booklet



MESSA
www.messa.org

Underwritten by

**Blue Cross Blue Shield of Michigan (BCBSM),
BCS Life Insurance Company (BCS), and
Connecticut General Life Insurance Company**

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Section 1: Who is Eligible for Coverage

1.1 Members

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

- any active, associate, service associate, retiree, or student member of the Michigan Education Association (MEA) as defined in the MEA Bylaws;
- any employee of MEA, MESSA, and Michigan Education Association Financial Services, Inc., or any subsidiary of any of the foregoing;
- subject to the MESSA Disaffiliation Policy, any employee of an education agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members;
- any retiree eligible for benefits under Section 91 of The Public School Employees Retirement Act of 1979, as amended (beginning at MCLA 38.1391);
- any other eligible individual as defined in the Michigan Education Special Services Association Bylaws, as amended.

An application is required if you are:

- enrolling for the first time;
- changing coverages for yourself or your dependents;
- changing school districts;
- covering dependent children age 19 or older.

1.2 Eligible Dependents

If you are covered, your eligible dependents include:

- your spouse;
- your unmarried children (including stepchildren, adopted children, and children for whom you are a legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday;
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (dependency for tax purposes, as defined by the Internal Revenue Service, is not required);
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically disabled, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their mental retardation or physical disability. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA Group Services to obtain the appropriate form to continue coverage;
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support;
- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are 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 and your employer:

- of any change in your employment status;
- when you wish to add a spouse or dependent(s);
- of any change to a dependent's eligibility for coverage;
- when a spouse or dependent is no longer eligible as defined above.

Special health care coverage guidelines apply to you and your spouse at age 65 during your active school employment. You should contact your school business office or MESSA for complete details. The Social Security Administration should be contacted regarding Medicare enrollment 120 days prior to attaining age 65.

1.3 End Stage Renal Disease (ESRD) -- Coordination with Medicare

MESSA/BCBSM/BCS will coordinate payment with Medicare for all covered services used by members with ESRD. Therefore, it is important that members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital or a freestanding facility approved by BCBSM to provide such services or in the home.

When Medicare Coverage Begins

For members with ESRD, Medicare coverage begins the first day of the third month following the month in which a regular course of dialysis begins, provided you file a valid application for Medicare with the Social Security Administration.

Example: Dialysis begins February 12. Medicare coverage begins May 1.

If you receive a kidney transplant or begin self-dialysis training in the first three months of dialysis, the waiting period is waived and Medicare coverage begins on the first day of the month the transplant is performed or the self-dialysis training begins.

When MESSA/BCBSM/BCS Coverage is the Primary or Secondary Plan

Your MESSA/BCBSM/BCS coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 33-month period ends, MESSA is your secondary plan and Medicare is your primary plan.

Once Medicare becomes your primary plan, you should apply for MESSA/BCBSM/BCS supplemental coverage. We will pay co-payments and we may pay deductibles, if applicable, for Medicare-covered services, depending on the type of supplemental coverage you select.

Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs **at the same time** as or **prior to** entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2001, and on September 1, 2001, you become entitled to Medicare because you have ESRD. In February 2002 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from September 1, 2001, through February 2004. Your employer's plan will be your secondary plan starting March 1, 2004.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:

If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period.

Example: You became entitled to Medicare in June 1999, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2001, you are diagnosed with ESRD and begin a regular course of dialysis. On August 1, 2001, you become entitled to Medicare because you have ESRD. Your employer's plan becomes your primary plan for the 30-month coordination period, from August 1, 2001, through January 31, 2003. Medicare becomes your primary plan on February 1, 2003.

If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. In August 2000, when you turn 65, you become entitled to Medicare. In January 2001 you begin a regular course of dialysis. On April 1, 2001, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

Section 2: When Coverage is Effective

The following information details the guidelines for your effective date of coverage:

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer;
- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer;
- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA;
- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA;
- Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

Section 3: When Coverage Terminates

Your Super Care 1 2003 Revision coverage ends on the date specified when the first of the following events occurs:

Termination of Employment—Coverage will end on the last day of the month in which you terminate employment.

Non-payment 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.

Termination of Employer's Participation—Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA/BCBSM Group Operating Agreement, and the MESSA/BCS Group Policy.

Member's Loss of Eligibility—Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in Section 1.

Dependent's Loss of Eligibility—Coverage will end on the date a dependent no longer meets the eligibility criteria described in subsection 1.2.

Note: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her ex-spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date that is 12 months following the date of the divorce, whichever is earlier.

Termination of the MESSA/BCBSM Group Operating Agreement—Coverage will end on the date the MESSA/BCBSM Group Operating Agreement or MESSA/BCS Group Policy terminates.

Member's Attainment of Age 65—Coverage will end on the first day of the calendar month in which a covered member becomes age 65, unless the covered member continues active school employment. If employment does not continue beyond age 65, the covered member will be automatically enrolled in the MESSA Limited Medicare Supplemental plan.

Medicare Elected As Primary—If you continue active school employment beyond age 65 and elect Medicare as your primary coverage, your coverage under the Super Care 1 2003 Revision plan will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; however, the spouse's coverage under the Super Care 1 2003 Revision plan will end on the first day of the month following such an election. See Section 21 for additional information.

*Note: If you cease active work or leave school employment, inquire as to what arrangements, if any, may be made to continue coverage. Also see Section 4, **Continuation of Health Coverage**. Contact MESSA Group Services for additional information.*

Section 4: Continuation of Health Coverage

4.1 COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA is a federal law that affects all employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60

days of the qualifying event. It provides the following coverage at the covered member's expense:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced;
- Coverage is extended to 29 months for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter;
- 36 months of coverage for qualified beneficiaries in cases of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare.

COBRA coverage can be terminated because:

- the 18, 29 or 36 months of COBRA coverage end;
- the required premium is not paid on time;
- the employer terminates its group health plan;
- the qualified beneficiary becomes entitled to Medicare coverage;
- the qualified beneficiary obtains coverage under a group health plan, unless the new health plan has pre-existing condition limitations that apply to the qualified beneficiary.

Please contact your employer for more details about COBRA.

4.2 Conversion Privilege

When you are no longer eligible for the Super Care 1 2003 Revision plan through your employer, an individual health care plan is available to you through BCBSM. Your benefits will change and coverage will be limited to your immediate family. There will be no interruption of coverage, provided you pay the premiums when due.

To ensure continuous coverage, you must make application with your employer within 31 days from the date your coverage terminates. Contact MESSA Group Services for additional information on how to apply for this coverage.

4.3 Surviving Family

Your dependents who are covered under the Super Care 1 2003 Revision plan on the date of your death should contact MESSA Group Services for information regarding continuation of coverage.

Section 5: How to Use Your Plan

5.1 Health Care Benefits

The health care benefits provided by this plan are underwritten by BCBSM and BCS. This means you can take advantage of the participating provider network and eliminate the need for any paperwork on your part. Please ask your physician if he/she participates with BCBSM. The following information explains how providers are paid:

Participating Provider—is a hospital, physician or other provider who signs an agreement with BCBSM to accept its payment as payment-in-full for covered services less any required deductibles or co-payments. It allows the provider to bill BCBSM and to receive payment directly from BCBSM. Reimbursement for services provided by a participating provider is based on BCBSM's determination of the approved amount for the service.

Advantages of Using Participating Providers:

- all paperwork is filled out by the provider;
- no out-of-pocket expenses beyond the plan's deductibles or co-payments;
- reduced out-of-pocket expenses in many cases; and
- no requirement to pay the participating provider at the time you receive services, other than deductibles or co-payments.

Showing Your Card—To receive services from a participating provider, just show your MESSA/BCBSM identification card. Your provider must have your contract and group numbers for billing purposes.

Help Yourself—Certain providers may participate with BCBSM on a per-claim basis. If your provider does not participate with BCBSM, ask your provider to participate on your claim. Per-claim participation by your provider may eliminate the surprise of non-covered out-of-pocket expenses that may be your responsibility.

Nonparticipating Provider—is a hospital, physician or other provider that does not have an agreement with BCBSM. Certain providers may participate on a per-claim basis by agreeing to accept BCBSM's approved amount as payment-in-full less any required deductibles or co-payments. If your provider does not agree to participate, covered services will be paid up to the approved amount as determined by MESSA/BCS. You will be responsible for any required deductible or co-payment.

If your provider does not complete a claim form, you will need to request an itemized statement/receipt and send it to MESSA. If written authorization is attached to the bill, MESSA will pay the provider; otherwise, payment will be sent to you.

Your itemized statement/receipt should contain the following information:

- member's name and contract number;
- full name of patient and date of birth;
- date of service;
- type of service (type of procedure performed);
- individual charge(s);
- diagnosis; and
- provider's name, address, telephone number, and taxpayer identification number.

5.2 Coverage Through Another Carrier

If you or your dependent(s) have coverage through another carrier that is primary (see **Coordination of Benefits** in subsection 22.1), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits.

MESSA will send you a benefit worksheet (explanation of benefits) when a claim is processed. Please keep these worksheets for future reference.

5.3 Care Outside of Michigan

If you or a covered dependent receives treatment in a licensed non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross Plan.

If you or a covered dependent receives any other type of service performed by a provider practicing outside of Michigan, you should ask for a statement or receipt. Be sure your statement/receipt is itemized with the same information identified under **Nonparticipating Provider**.

Send this bill to MESSA. If written authorization is attached to the bill, we will pay the provider; otherwise, payment will be sent to you.

5.4 BlueCard Program

If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any deductible or co-payment required under BCBSM. After the Host Plan pays the provider, BCBSM reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, we will pay for the services as described above.

If your plan requires a deductible, that amount will apply to services received outside of Michigan. If your plan requires a co-payment, your co-payment for services received outside of Michigan will be calculated using the designated payment level.

Note: Your deductible and co-payment requirements are based on your plan and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- the services are not a benefit in this booklet;
- coverage for services performed outside of Michigan is excluded;
- the services are performed by a vendor or provider who has a contract with BCBSM for those services.

5.5 Filing Deadlines

All claims must be submitted to MESSA/BCBSM/BCS within two years of the date of service. If you have any questions regarding your medical claims, please call MESSA Benefits Administration.

Section 6: General Provisions

The following information will explain the health care benefits available to you and your covered dependents and your financial responsibilities under the Super Care 1 2003 Revision plan. When used in the following sections of this booklet, the words “you” and “your” mean a covered member and his/her covered dependents. The term “we” refers to MESSA, BCBSM or BCS.

6.1 Benefit Periods

All benefit periods (except where noted), are based on a calendar year, beginning January 1 and ending December 31 of that year.

6.2 Deductible

During each benefit period you are required to meet an individual deductible or a family deductible before payment will begin for covered services subject to the deductible. Your payments for services covered are applied toward the deductible requirement.

- **Carryover Provision**—Eligible expenses incurred and applied toward your deductible during the last three months of any calendar year will be applied toward the following year's deductible.
- **Common Accident Provision**—If two or more covered individuals in your family are injured in the same accident, only one individual deductible will be applied to the

combined covered charges incurred as a result of the accident in both the calendar year in which the accident occurred and the following calendar year.

- **Common Communicable Disease Provision**—This applies when more than one covered individual in your household contracts the same communicable disease, and the second person contracts the disease within three months of the date it was contracted by the first person. In this situation, only one individual deductible will be applied to the combined covered charges incurred as a result of the disease in both the calendar year in which it was contracted by the first person and the following calendar year.

After you have met your deductible, the plan will pay 90% (except where noted) of the approved amount for all covered services. The remaining 10% is your co-payment.

- **Family Stop-loss**—This plan has a special feature that limits your out-of-pocket co-payment expenses for each benefit period. Once you have paid \$1,000 in co-payments under the BCBSM certificate and your BCS policy combined, the plan will pay 100% of the approved amount for covered services for the rest of that calendar year. The co-payment liability does not include the deductible, charges that exceed specified benefit maximum amounts or an approved amount, or any charges that are not covered under this plan or by BCS.

6.3 Physician

A “physician” is a doctor of medicine (MD) or osteopathy (DO) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, dentist, podiatrist, or a doctor of chiropractic 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 he/she is legally qualified to perform.

A “physician” is also a person who is licensed under Public Act 368 Public Acts of Michigan 1978, as amended (beginning at MCLA 333.18221) 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.

6.4 Approved Amount

Covered charges, fees and expenses submitted by participating providers will not include any amount in excess of BCBSM's approved amount.

Non-Participating Provider charges, fees and expenses, for services, supplies or care covered under your BCBSM plan, in excess of BCBSM's approved amount are covered at the BCS approved amount. (A Non-Participating Provider is a hospital, doctor, pharmacy or other provider that does not have an agreement with BCBSM to accept its payment as payment-in-full for covered services less any required deductibles or co-payments.)

6.5 Medically Necessary

Benefits under this plan are available for services that are determined by MESSA/BCBSM/BCS to be medically necessary. This includes services, supplies or care provided by a hospital, physician or other covered health care provider to diagnose or treat the patient's medical condition, illness or injury. Services must be consistent with accepted standards for good medical practice and must not be primarily for the convenience of the member, physician or family.

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as the standard of care and be medically necessary for the illness or injury being treated.

6.6 Pre-Admission Review (PAR)

You or your physician must request prior approval from MESSA for admissions to a hospital or other facility. If Pre-Admission Review (PAR) guidelines are not followed, you may have additional financial responsibilities in excess of the deductible and co-payment requirements. For additional information about PAR, please refer to Pre-Admission Review in Subsection 7.2.

6.7 Medical Case Management (MCM)

This program is designed to assist you if you are diagnosed with a catastrophic illness or injury. The program is tailored to meet your individual needs based on your unique medical condition. Prior approval must be obtained from MESSA before benefits under MCM can begin. Eligibility for and termination of MCM benefits are made on a case-by-case basis in accordance with BCBSM/BCS's criteria. For additional information, please refer to **Medical Case Management (MCM)** Section 19.

Section 7: Hospital Benefits

The following information explains your inpatient hospital benefits and applicable limitations:

7.1 Inpatient Hospital Benefits

After you have followed the Pre-Admission Review (PAR) requirements explained below and your admission has been determined by MESSA to be medically necessary, inpatient semi-private room and board and covered ancillary services are paid at 100% of the approved amount. Inpatient private room and board are paid at 100% of the approved amount when medically necessary.

Private room rates, when not medically necessary, are paid at the hospital's average charge for semi-private accommodations plus \$5 per day. However, if you are admitted into a nonparticipating hospital that doesn't have semi-private accommodations, reimbursement is made at 80% of the hospital's minimum charge for a private room plus \$5 per day.

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

- 48 hours following a vaginal delivery;
- 96 hours following a delivery by cesarean section.

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

We may not set the level of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours).

Inpatient benefits are limited to facilities that are state licensed as hospitals and that meet all

plan requirements for coverage. Benefits are not payable for room and board charges incurred as a result of treatment at any facility that does not meet these criteria.

7.2 Pre-Admission Review (PAR)

If you satisfy the following PAR requirements, benefits will be paid as indicated under "Inpatient Hospital Benefits." If you do not satisfy the following requirements, you may be responsible for 20% of the covered physician and hospital charges.

Elective Admission Requirements—You or your physician must request prior approval for all elective (non-emergency) admissions to a hospital. To comply with PAR, the following requirements must be satisfied:

A completed PAR form must be sent to MESSA at least two weeks before the scheduled admission. You must complete your section of the PAR form (included in your Super Care 1 2003 Revision Kit) and your physician must complete the remaining portion of the form and mail it to the following address:

**Michigan Education Special Services Association
PRE-ADMISSION REVIEW
PO Box 2560
East Lansing, Michigan 48826-2560**

If a two-week notice is not possible, you or your physician can call MESSA for an immediate review of the admission request. The toll-free telephone number is:

800.336.0022

MESSA will review your physician's request and determine whether your admission will be authorized under BCBSM's medical necessity criteria. MESSA will send written notice of the decision to you and, if necessary, to your physician and the hospital.

Emergency Hospital Admissions—Advance approval is not required for emergency admissions. However, your physician or hospital must notify MESSA, in accordance with established BCBSM guidelines. If the admission takes place in a facility outside of the state of Michigan or that does not participate with BCBSM, MESSA must be notified on the next regular business day. MESSA will determine whether or not the admission will be authorized under BCBSM's medically necessary criteria. MESSA will send written notice of the decision to you and, if necessary, to your physician and the hospital.

Requesting Additional Days—The hospital or your physician can request additional days beyond the days initially approved. Whenever possible, such requests should be made up to 48 hours before the end of the days initially approved. MESSA will let you, your physician and the hospital know if the request for additional days has been approved.

If the extension is not approved and your hospital admission exceeds the number of days determined by MESSA to be medically necessary, you may be responsible for the following:

- charges for inpatient hospital room and board;
- other charges for medical services and supplies furnished by the hospital;
- physician charges for inpatient hospital visits;
- any other charges related to the days not approved.

Requesting Approval After Admission—If your physician fails to get approval before you are admitted, MESSA will still review a request, either while you are in the hospital or after your discharge. The disadvantage is that you will not know before the admission whether the care is covered and you may be responsible for 20% of all covered charges.

Appealing a Non-approved Admission or Extension—Your physician may appeal all decisions by requesting a review by MESSA.

Receiving Services Without Prior Approval—If the required Pre-Admission Review is not obtained, those covered charges stated above that are determined to be medically necessary for inpatient hospital confinement and physician in-hospital visits may be reimbursed at 80% of the amount that would otherwise have been paid in accordance with the Super Care 1 2003 Revision Plan and Pre-Admission Review. You may be responsible for the remaining 20%. If you were given notice of MESSA's denial of benefits before the admission began, or if you accepted such liability by entering into a prior agreement with your physician and hospital, you may be responsible for all charges (both hospital and physician) resulting from the admission.

Section 8: Outpatient Hospital Benefits

When performed in the outpatient department of a hospital, benefits include:

8.1 First Aid Emergency Care

Outpatient treatment due to an accidental injury is paid at 100% of the approved amount for hospital or physician services. Benefits include the initial examination and treatment and follow-up treatment of accidental injuries within 90 days of the injury. Beyond 90 days, follow-up care is paid at 90% of the approved amount, subject to the deductible.

8.2 Life-Threatening Medical Emergency Care

When provided in an outpatient department of a hospital, the initial examination and treatment of conditions determined to be medical emergencies are paid at 90% of the approved amount.

A medical emergency is an illness that is a life-threatening condition requiring immediate attention and treatment. The condition must have severe symptoms that occur suddenly and unexpectedly, and be such that failure to render immediate treatment could reasonably be expected to result in serious jeopardy to your health or to a pregnancy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

8.3 Other Medical Emergency Care

Services for medical emergency care, determined not to be life-threatening, provided in the outpatient department of a hospital, are paid at 90% of the approved amount after your deductible has been met.

8.4 Scheduled Outpatient Surgery

Hospital charges for covered, scheduled outpatient surgery are paid at 100% of the approved amount. Surgical fees are covered under the **Surgical Benefits** section. Please refer to Section 11.

Section 9: Skilled Nursing Facility Benefits

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.

If care is received in a **participating facility**, benefits for skilled nursing care admissions are payable for room and board charges and covered miscellaneous charges at 90% of the approved amount after your deductible has been met. A skilled nursing admission must occur within 14 days of a hospital confinement for the same condition, or your physician 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.**

If care is received in a **non-participating facility**, room and board charges and miscellaneous charges are paid at 90% of the approved amount after your deductible has been met. A skilled nursing admission must occur within 14 days of a 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.**

Section 10: Inpatient Medical Benefits

10.1 Inpatient Medical Care

After you have followed MESSA's Pre-Admission Review (PAR) requirements (see **Pre-Admission Review** in subsection 7.2) and your hospital admission has been determined to be medically necessary, inpatient medical care billed by your licensed physician is paid at 100% of the approved amount. This includes care for general medical conditions as well as nervous and mental conditions.

Benefits include inpatient care received in special care units (e.g., intensive, burn and cardiac care) and inpatient consultation when the services of a consulting physician are required in the diagnosis and treatment of a condition.

10.2 Inpatient Routine Newborn Medical Care

Visits by a participating or nonparticipating provider are paid at 100% of the approved amount.

Section 11: Surgical Benefits

11.1 Surgery

Surgical procedures determined to be medically necessary and performed by a licensed physician are paid at 100% of the approved amount. Inpatient surgical procedures are subject to the PAR requirements as outlined in subsection 7.2.

- **Multiple Surgeries**—Performed by the same physician on the same day and through the same incision are considered related. This plan will pay for the more costly surgery. However, when surgeries are made through separate incisions, the more costly surgery is paid at 100% of the approved amount and the less costly surgery at 50% of the approved amount.
- **Bilateral Surgical Procedures**—If performed through separate incisions, both procedures are considered as one procedure and reimbursement will be made at 150% of the approved amount for the respective unilateral procedure.

- **Voluntary Sterilization**—Services are covered for voluntary sterilization, regardless of medical necessity, for both males and females. However, a reversal of a sterilization is not covered.
- **Contraceptive Devices**—Services for the insertion and removal of an intrauterine device by a licensed physician are covered.

11.2 Technical Surgical Assistance

Surgical assistance provided by a licensed physician is paid at 100% of the approved amount provided for surgical procedures that require technical surgical assistance, as determined by MESSA/BCBSM.

11.3 Anesthesia

Services for the administration of drugs or gases, either in an inpatient or outpatient hospital setting, are paid at 100% of the approved amount when performed with other covered services. Anesthesia must be administered and billed by a certified registered nurse anesthetist or a licensed physician other than the operating surgeon or the surgeon's assistant. Anesthesia services are also payable when provided in an ambulatory surgery facility.

Note: Direct reimbursement is not available for anesthesia services provided by a certified registered nurse anesthetist in locations other than those included above.

Section 12: Bone Marrow Transplant Benefits

When directly related to up to two single transplants per member, per condition, MESSA/BCBSM/BCS will pay for the following services:

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;
- 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 or umbilical cord blood, if the donor is:
 - A first degree relative and matches at least four of the six important HLA genetic markers with the patient* **or**
 - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. [This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.]*

Note: Harvesting and storage will be covered if it is not covered by the donor's insurance. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

- High dose chemotherapy or total body irradiation;
- Infusion of bone marrow, peripheral blood stem cells, 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 or peripheral blood stem cells;
- Purging or positive stem cell selection of bone marrow or peripheral blood stem cells;
- High dose chemotherapy or total body irradiation;
- Infusion of bone marrow or peripheral blood stem cells;
- Hospitalization.

Note: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in Section 25.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients);
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients);
- Aplastic anemia;
- 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);
- Osteoporosis;
- 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;
- 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.

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients);
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients);
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum;
- Hodgkin's disease (high risk, refractory or relapsed patients);

- Neuroblastoma (stage III or IV);
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients);
- Multiple myeloma;
- Primitive neuroectodermal tumors;
- Ewing's sarcoma;
- Medulloblastoma;
- Wilms' tumor;
- Primary amyloidosis;
- Rhabdomyosarcoma;
- Mantle cell lymphoma.

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

MESSA/BCBSM/BCS does not pay the following for bone marrow transplants:

- Services that are not medically necessary (see Section 25 for the definition of medically necessary);
- Services provided by persons or entities that are not legally qualified or licensed to provide such services;
- Services rendered to a donor when the donor's health care coverage will pay for such services;
- 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;
- An allogeneic tandem transplant;
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future;
- Experimental and investigational services;
- Any other services or admissions related to any of the above named exclusions.

Section 13: Human Organ Transplant Benefits

Human organ transplant services must be preapproved. The preapproval process allows a provider to know if we will cover the proposed human organ transplant surgery, related services, hospital admission and length of stay at the hospital before treating you. If preapproval is not obtained before you receive the human organ transplant services described below, they will not be covered.

A decision to preapprove services will be based on the information your provider submits for review. MESSA/BCBSM/BCS reserves the right to request other information to determine if preapproval is appropriate.

When performed in an approved facility, MESSA/BCBSM/BCS pays 100% of the approved amount for transplantation of the following human organs:

- heart;
- heart-lung(s);

- liver;
- lung(s);
- pancreas;
- partial liver;
- lobar lung;
- simultaneous pancreas-kidney;
- small intestine (small bowel);
- combined small intestine-liver.

Services for kidney, cornea, skin and certain bone marrow transplants are covered as standard benefits in this booklet, unless they are determined to be experimental or investigational in nature. They are not subject to the guidelines outlined in this section.

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted, standard treatments. To be covered under this plan, these procedures must be recognized as the standard of care and be medically necessary for the illness or injury being treated.

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 directly related to the transplant, MESSA/BCBSM/BCS pays for:

- Facility and professional services;
- Anti-rejection drugs and other transplant-related prescription drugs, as needed. Our payment will be based on the amount we determine to be reasonable and necessary and is subject to the **\$1,000,000** lifetime maximum for the human organ transplant benefit;
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
 - occurs **during** the benefit period and
 - is a **direct** result of the organ transplant surgery

Note: MESSA/BCBSM/BCS will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under any BCBSM/BCS certificates.

MESSA/BCBSM/BCS also pays for the following:

- up to \$10,000 for travel, meals and lodging. This includes:
 - cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living related donor);
 - reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient;
 - reasonable and necessary costs of meals up to \$40 per day for the patient and person(s) eligible to accompany the patient.
- cost of acquiring the organ. This includes:
 - surgery to obtain the organ;
 - storage of the organ;
 - transportation of the organ;
 - payment for covered services for donors if the donor does not have transplant services under any health care plan.

*Note: MESSA/BCBSM/BCS will pay what we determine to be reasonable and necessary for the cost of acquiring the organ. The total payment for all services combined for each organ transplant will not be more than the **\$1,000,000** lifetime maximum for the specified human organ transplant benefit.*

Section 14: Diagnostic Benefits

The following diagnostic services, when medically necessary (refer to Section 6.5 **Medically Necessary**) and ordered by a physician, are paid at 100% of the approved amount:

14.1 Diagnostic Radiology

Benefits are payable for diagnostic x-rays, isotopes, and ultrasounds required in the diagnosis of an illness or injury. CAT scans and magnetic resonance imagings (MRI) are also payable when medically necessary.

14.2 Laboratory and Pathology Services

Benefits are payable for laboratory and pathology tests that are required in the diagnosis of an illness or injury.

14.3 Diagnostic Services

Benefits are payable for EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury. Benefits are not payable for screening services, except for cancer screening as described in Section 17.

Section 15: Therapy Benefits

The following therapy services are paid as indicated below if obtained in the outpatient department of a hospital, a physician's office or a freestanding facility. Therapies must be medically necessary and ordered by and performed under the supervision or direction of a legally qualified physician except where noted. Benefits include the following:

15.1 Physical Therapy

Services are paid at 90% of the approved amount after you have met your deductible. Services must be performed by 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.

15.2 Speech and Language Pathology Services

Services are paid at 90% of the approved amount after you have met your deductible. Services must be provided by a registered speech therapist. For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

15.3 Chemotherapy

Services for a malignancy are paid at 100% of the approved amount. Benefits include the cost of administration, physician services, and drugs approved by the Food and Drug Administration, except when the treatment or drug is considered experimental or investigational in nature. MESSA/BCBSM/BCS also pays for antineoplastic drugs when

Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

15.4 Radiation Therapy

Services for a malignancy are paid at 100% of the approved amount. Benefits include x-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigational in nature.

15.5 Hemodialysis

Services are paid at 90% of the approved amount after your deductible has been met.

15.6 Outpatient Psychotherapy

Services are paid at 90% of the approved amount after your deductible has been met. Services must be provided by a licensed physician, a fully licensed psychologist, or a Michigan MSW who is a member of the Academy of Certified Social Workers, or obtained at a participating BCBSM outpatient psychiatric care center. Benefits are limited to a maximum of 50 visits per person per calendar year. A visit will be counted for each treatment that lasts one hour or less.

Treatment periods extending beyond one hour will be counted as multiple visits, with each additional hour (or portion of an hour) counting as one visit. Electroshock therapy treatments are not subject to the 50 visit maximum.

15.7 Outpatient Substance Abuse Therapy

Services provided in a licensed substance abuse facility are paid at 90% of the approved amount after your deductible has been met.

15.8 Vision Therapy Services

Services must be performed by a qualified orthoptist to correct defective visual habits and are paid at 90% of the approved amount after your deductible has been met. Benefits are not provided for the following:

- learning disabilities;
- reading problems including dyslexia;
- reading or educational enhancement;
- non-accommodative strabismus, such as muscle paralysis.

15.9 Allergy Therapy Services

Allergy therapy services are paid at 90% of the approved amount after your deductible has been met. Covered services include scratch or puncture tests, therapeutic treatments (i.e., injections) and supplies.

Section 16: Hospice Care Benefits

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 referral by your attending physician. Benefits become available when:

- the covered patient is terminally ill with a life expectancy of six 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.

The following services for the patient will be paid at 100% of the approved amount up to an annual maximum that is reviewed and adjusted periodically (contact MESSA for information about the current maximum amount):

- 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 patient at home;
- part-time skilled nursing care (full-time 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); and
- charges for physician services.

For the patient and other covered individuals of the patient's family, counseling services provided by, or on behalf of, the hospice facility are covered also. This benefit ends:

- 12 months after the date of the first family unit counseling session;
- 18 months after the date the hospice benefit began; or
- upon payment of the maximum hospice benefit payment, whichever occurs first.

Section 17: Cancer Screening Benefits

Preventive screening for cancer is covered at 100% of the approved amount. This includes the services listed below for screening of the prostate, breast, uterus, colon and rectum in individuals without symptoms or who are not considered to be at risk. Because cancer screening guidelines may change as advances are made in medical research and technology, additional services, as recommended by the American Cancer Society, may also be covered. Please contact MESSA regarding current benefits for cancer screening services.

17.1 Prostate

One prostate examination in any three-year period, if you are between the ages of 20 and 39. One prostate examination per calendar year, if you are age 40 and older. This examination is done by a physician during an office visit.

17.2 Breast

One breast examination per calendar year. One baseline mammogram if you are between the ages of 35 and 39. One mammogram per calendar year if you are age 40 or older.

17.3 Uterus

One pelvic examination and one pap smear per calendar year.

17.4 Colon and Rectum

One digital rectal examination is allowed every year if you are age 40 or older. One stool slide test every year if you are age 50 or older. One proctosigmoidoscopy examination every three to five years after age 50 following two negative examinations, one year apart.

Note: This benefit will apply only when ordered by a physician and billed as cancer screening.

Section 18: Other Miscellaneous Benefits

The following services and supplies, when medically necessary, are paid at 90% of the approved amount (except for home health care, as noted below) after your deductible has been met:

18.1 Home Health Care

Services are paid at 100% of the approved amount for medically necessary services when 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. 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:

- intermittent skilled visits (full-time care is not included) by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN);
- 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;
- rental of medical equipment (not to exceed purchase price);
- physical therapy, occupational therapy, speech and language pathology services, social service guidance and nutritional guidance provided by a home health care agency; and
- hospital services and supplies related to the injury or illness that required or would have required the hospital confinement and would normally be provided by the hospital.

Note: Meals and general housekeeping services are not covered.

18.2 Obstetrics

Prenatal and postnatal services are paid at 100% of the approved amount. Services provided by the physician attending the birth are paid at 100%.

18.3 Outpatient Diabetes Management Program

Covered outpatient services determined to be medically necessary to treat and control diabetes are paid at 90% of the approved amount after your deductible has been met. The services are:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- insulin pumps;
- test strips for glucose monitors;
- visual reading and urine strip tests;
- lancets;
- spring-powered lancet devices;
- syringes;
- insulin;
- medical supplies required for the use of an insulin pump;
- non-experimental drugs to control blood sugar;
- medication prescribed by a doctor of podiatric medicine, M.D. or D.O. to treat foot

ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes;

- diabetes self-management training conducted in a group setting, whenever practicable, if:
 - self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge;
 - your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment.

The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

Note: Coverage for syringes, insulin and prescription drug benefits are provided if you do not have coverage under a prescription drug plan.

Diagnosis related education programs, including, but not limited to, outpatient diabetic education programs are approved by MESSA/BCBSM/BCS after the deductible has been met.

18.4 Physician Office Call

Includes diagnosis or treatment, but not routine physician care.

18.5 Private Duty Nursing

Medical services requiring the skill level of a Registered Nurse or Licensed Practical Nurse on an hourly basis when prescribed by a physician.

18.6 Durable Medical Equipment

The rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician. Benefits include items such as hospital beds or wheelchairs. Items such as air purifiers, whirlpools, air conditioners, and exercise equipment are not covered.

18.7 Medical Supplies

Certain medical supplies when prescribed by a physician. Covered items include but are not limited to:

- ostomy supplies;
- needles and syringes;
- compression or anti-embolism stockings, when prescribed for vascular conditions; and
- surgical brassieres following a mastectomy (limited to four per any 12-consecutive-month period).

18.8 Ambulance Service

Transportation services by professional ambulance to or from the nearest hospital equipped to furnish treatment. Within the United States and Canada, benefits are payable for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient's transportation is covered.

Note: Ambulance transportation is not covered for patient or family convenience, or for physician preference.

18.9 Ambulatory Surgery Facility Services

Facility services provided by an ambulatory surgical facility. The services must be directly related to performing ambulatory surgery. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral surgery to be admitted to an ambulatory surgery facility. Covered services include:

- use of the ambulatory surgery facility;
- anesthesia services and materials;
- recovery room;
- nursing care by or under the supervision of a registered nurse;
- drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery;
- oxygen and other therapeutic gases;
- administration of blood;
- skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissues, as well as the cost of processing and storage;
- routine laboratory services related to the surgery or a concurrent medical condition;
- radiology services performed on equipment owned by and performed on the premises of the facility. Services must be necessary to enhance the surgical service;
- housekeeping items and services.

18.10 Certified Nurse Midwife Services

Covered services performed by a certified nurse midwife include the following:

- normal vaginal delivery when provided in:
 - an inpatient hospital setting; or
 - a birthing center that is hospital affiliated, state licensed and accredited as defined and approved by BCBSM;
- prenatal care;
- postnatal care, including a Papanicolaou (PAP) smear during the six-week visit.

18.11 Certified Nurse Practitioner Services

Covered services performed by a certified nurse practitioner when the services are provided in any location, except a hospital inpatient setting.

Note: Benefits are not payable for services:

- not covered by your plan;
- performed when you are a hospital inpatient;
- related to treatment you receive under a BCBSM psychiatric or substance abuse managed care program.

18.12 Braces, Prosthetic and Orthotic Appliances

External appliances when they replace an absent part of the body or are intended to correct a defect of form or a function of the body. Appliances must be prescribed by a physician. Repairs or replacements due to wear and tear or natural growth are covered, unless otherwise specified. Benefits include, but are not limited to:

- artificial eyes, ears, nose, larynx, limbs;
- eyeglasses and hearing aids when required because of an accidental injury;
- orthopedic shoes meeting guidelines established by MESSA/BCBSM;

- one pair of prescription eyeglasses or contact lenses when required because of cataract surgery or the absence of an organic lens;
- external breast prosthesis following a mastectomy;
- prefabricated custom-made orthotic appliances;
- wigs following chemotherapy or radiation therapy, and for alopecia areata and alopecia totalis, at 90% of the approved amount after your deductible has been met.

18.13 Dental Services

Dental treatment by a licensed dentist or dental surgeon required because of an accidental injury to sound, natural teeth. Charges by a dental surgeon for the removal of cysts and tumors of the mouth and jaw, and the extraction of impacted teeth are covered. Maxillofacial prosthesis when BCBSM approved; these devices may be provided by dentists.

18.14 Optometrist Services

Covered services performed by a licensed optometrist within the scope of his or her license.

Note: Services performed by an optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under BCBSM's vision program.

18.15 Additional Benefits

Certain eligible expenses for services, supplies or care not otherwise covered under the BCBSM coverage are covered under the group policy underwritten by BCS Life Insurance Company. These covered expenses include:

- Manipulations (above the BCBSM approved amounts), modalities, and orthotics charged by a chiropractor for an initial visit following traumatic injury after the deductible has been met;
- Outpatient physical therapy billed by a skilled nursing facility at 90% of the approved amount after the deductible has been met;
- Prescription medication (given in a doctor's office or hospital clinic, out-of-state charges, and member paid charges) after a \$5 co-payment has been met;
- Maxillofacial prosthesis when BCBSM approved; these devices may be provided by dentists;
- Five (\$5) dollars per day toward a non-medically necessary private room rate;
- Take home drugs, equipment and supplies from hospitals billed along with emergency room treatment or inpatient stay, or outpatient scheduled surgery charges, at 90% of the approved amount for emergency room billings, otherwise at 100% of the approved amount;
- Suppliers' charges for rental of equipment used to do pneumogram at home at 90% of the approved amount after the deductible has been met;
- Consultations with Christian Science Practitioners at 90% of the approved amount after the deductible has been met;
- 10% co-pay on a 24-hour observation stay in a participating facility;
- 10% co-pay for physical therapy due to accidental injury;
- Out-of-state inpatient bills more than one (1) year old;
- MESSA covered charges that are exclusions in out-of-state Blue Cross plans for services performed out-of-state after the deductible, if any, has been met;
- BCBSM advance payment plan co-pays and deductibles;
- Coordination of benefit balances on inpatient out-of-state facilities;

- Charges for eligible services or care provided by a social worker who is a member of the Academy of Certified Social Workers (ACSW) at 90% of the approved amount after the deductible has been met;
- Mail Order Prescription Drugs;
- Medical Weight Loss Treatment. Services performed by a qualified physician for the treatment of morbid obesity are paid at 90% of the approved amount after your deductible has been met. Covered laboratory services ordered for your weight loss treatment are paid at 100% of the approved amount. To qualify for this benefit, your Body Mass Index must define you as morbidly obese. For this condition, a special benefit period begins with the date of the first service and ends three years following that date;
- Nutritional Counseling. Services of a registered dietician will be paid directly if charges are part of inpatient care, or a diabetic or cardiac rehabilitation program. Counseling for other conditions is paid only if medically necessary and ordered by a physician;
- Co-payments and deductibles associated with prenatal and postnatal services.

Section 19: Medical Case Management (MCM)

This is a benefit designed to assist you if you are diagnosed with a catastrophic illness or injury. It is tailored to meet your unique medical needs. Prior approval must be obtained from MESSA before benefits under MCM can begin. The payment of benefits will be based on an objective review of your medical status, current treatment plan, projected treatment plan, long-term cost implications, and the effectiveness of care.

Eligibility for MCM benefits and termination of such benefits is made on a case-by-case basis and in accordance with BCBSM/BCS criteria. The following are examples of medical conditions considered for MCM:

- pancreatitis;
- major head trauma;
- spinal cord injury;
- amputations;
- multiple fractures;
- severe burns;
- neonatal high-risk infants;
- severe stroke;
- multiple sclerosis;
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease);
- Acquired Immune Deficiency Syndrome (AIDS);
- Crohn's disease; and
- Cancer.

Medical Case Management is designed to give you and your family members flexibility and direct involvement in the management of your health care.

Note: Prior approval must be obtained from MESSA before the program can begin.

If you have any questions regarding MCM, please contact the MESSA Health Care Relations department at 800.441.4626.

Section 20: Exclusions and Limitations

The following exclusions and limitations apply to the Super Care 1 2003 Revision plan. These are in addition to limitations appearing elsewhere in this booklet:

- artificial insemination (including in vitro fertilization) and related services;
- treatment of work-related injuries covered by workers' compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer;
- charges incurred because of war, declared or undeclared, or an act thereof, or for injury or sickness sustained or contracted in the armed forces of any country, or for services provided in a Veteran's Administration Hospital for a covered person with a military service-connected disability, or for services, supplies or treatments provided or covered under any governmental plan or law, or that would have been furnished without cost in the absence of this coverage, or for which the covered person has no legal obligation to pay. However, care and services are payable if federal laws require the government-sponsored program to be secondary;
- clerical fees, including fees for patient records;
- custodial care or basic care that can be provided by someone other than an RN or LPN;
- 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;
- educational care and cognitive therapy;
- eye examinations and eyeglasses or other corrective visual appliances except as specified under miscellaneous benefits;
- hearing aids (except as previously specified);
- inpatient hospital confinement for the sole purpose of testing for, or detoxification of, allergy or allergy-related conditions;
- items for the personal comfort or convenience of the patient;
- radial keratotomy and related services;
- reversal of sterilization procedures and related services;
- routine health examinations and related services or routine screening procedures including pre-marital or pre-employment examinations (except as previously specified under cancer screening benefits);
- services, supplies or treatment provided by an immediate relative or by anyone who customarily lives in the member's household. For purposes of coverage under this plan, an immediate relative is a spouse, parent, sibling or child of the covered person or a mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law or daughter-in-law of the covered person;
- services that are not BCBSM benefits;
- anti-rejection drugs that do not have Food and Drug Administration marketing approval;
- items that are not considered directly related to travel, meals and lodging in conjunction with the initial surgery and hospitalization for a human organ or bone marrow transplant (examples include, but are not limited to, the following: clothing, personal hygiene and related services, car maintenance, babysitters or daycare services, and entertainment);
- services and supplies that are not medically necessary according to accepted standards of medical practice, including any services that are experimental or investigational in nature;

Note: Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as the standard of care and be medically necessary for the illness or injury being treated.

- services, treatments, or care provided after the coverage termination date, except hospital inpatient services for an admission that began before the termination date;
- surgery for cosmetic or beautifying purposes, except for:
 - correction of deformities present at birth;
 - correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy;
 - conditions caused by accidental injuries or illness; and
 - traumatic scars;
- 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; and
- transportation expenses (except as previously specified) including meals and lodging.

Section 21: Medicare - General Information

The Medicare health care program is designed to provide health care benefits to persons age 65 and older, and to certain disabled persons. The Social Security Administration is the sole authority for determining eligibility, called "entitlement," for Medicare coverage. If you are eligible for care under this program, you are called a "beneficiary."

Generally, except for certain disability situations, you cannot become eligible for Medicare until age 65. You are eligible to enroll during the seven-month period beginning three months before, and ending three months after, the month in which you reach age 65. You must apply for Medicare coverage through your local Social Security office.

When you reach age 65 and are eligible for Medicare, but continue working, you have two options:

- You may continue Super Care 1 2003 Revision as your primary health insurance plan. To do so requires no action by you. If you choose this option, your health insurance benefits will be the same as those provided to your associates under the age of 65. You can also enroll in Medicare under this option. If you enroll in Medicare, you may have additional hospital and medical benefits available.
- You may elect Medicare as your primary health insurance plan. To make this election, you must reject coverage under the Super Care 1 2003 Revision plan in writing. If you choose this option, your spouse will also no longer be eligible for the Super Care 1 2003 Revision plan. In addition, your employer is prohibited by federal regulations from providing you with a Medicare supplement plan.

If you cover a dependent spouse age 65 or older, your employer must provide your spouse the same benefits you select until you retire. This rule also applies if your spouse is the working employee, and you are age 65 or older.

Section 22: Additional Plan Information

22.1 Coordination of Benefits

Benefits payable under this plan will be coordinated pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984, as amended (beginning at MCLA 550.251). Coordination of benefits (COB) is used when you are eligible for payment under more than one group health, dental, vision or automobile no-fault insurance plan. This provision is to assure you that your covered expenses will be paid, but that the combined payments of all programs will neither exceed the amount of the actual cost, nor the amount that would have been paid in the absence of other coverage. Under COB, the plan that has the first obligation to pay is called the primary plan.

The guidelines used to determine the primary plan include, but are not limited to, the following:

- A group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary; otherwise,
- The plan sponsored by the employer of the person receiving the treatment is primary; or
- If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan that has covered the dependent the longest is primary. However, benefits for children of divorced or separated spouses are determined in the following order:
 - Plan of parent having financial responsibility as designated by court decree;
 - Custodial parent's plan;
 - Plan of the custodial parent's new spouse (if remarried); or
 - Plan of non-custodial parent.

If the primary plan cannot be determined using the above guidelines, then the plan covering the person the longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off and there is also coverage through a plan not involving a retired or laid off employee, the plan through the person who is not a retiree or laid off employee will be primary.

These COB provisions shall apply to any government or tax-supported program, such as Medicare, unless federal laws require such program to be secondary to your coverage. These provisions shall also apply to any benefits or services provided by group student health programs. Except for automobile no-fault insurance coverage, these COB provisions shall not apply to any non-group policy.

Note: The term "Medicare" means those benefits available under Medicare Part A and Part B whether or not you are entitled to or have subscribed for Medicare Part A and Part B.

22.2 Release of Information

Each person covered under this plan hereby authorizes physicians, hospitals and other providers of service to furnish to MESSA/BCBSM/BCS, upon their request, information relating to services the covered person is or may be entitled to under this plan. Physicians, hospitals and other providers of services are hereby authorized to permit MESSA/BCBSM/BCS to examine their records with respect to the services and to submit to MESSA/BCBSM/BCS reports of the services in the detail MESSA/BCBSM/BCS requests. This provision shall be restricted by any law requiring an individual's written consent to release

information regarding a contagious disease. All information related to treatment of the covered person will remain confidential and will be disclosed by MESSA/BCBSM/BCS only as authorized by law.

22.3 Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this booklet, MESSA/BCBSM/BCS will not pay for any services, treatment, care or supplies provided before your coverage with MESSA begins or after your coverage with MESSA ends. If your coverage begins or ends while you are an inpatient at a facility, payment will be based on the facility's contract with BCBSM. 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/BCBSM/BCS coverage or after it ends.

22.4 Experimental or Investigational Services

MESSA/BCBSM/BCS does not pay for experimental or investigational treatment or for services that are related to experimental or investigational treatment.

MESSA/BCBSM/BCS does not pay for experimental or investigational drugs, or for administrative costs related to health care services or research management.

Note: This does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

However, MESSA/BCBSM/BCS does pay for *conventional* (non-experimental) services related to experimental or investigational treatment when:

- provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM); and
- covered under this booklet when provided during conventional treatment.

Additional Notes:

- MESSA/BCBSM/BCS does not provide coverage for conventional services not otherwise covered in this booklet.
- MESSA/BCBSM/BCS does not provide coverage for experimental or investigational treatment rendered during a BCBSM-approved oncology clinical trial.
- MESSA/BCBSM/BCS does not provide coverage for experimental or investigational drugs that are normally covered by other funding sources (e.g., experimental or investigational drugs funded by a drug company).
- MESSA/BCBSM/BCS does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.
- The BCBSM medical director is responsible for determining whether the use of any service is experimental or investigational. For example, the services may be determined to be experimental or investigational when there is:
 - a written experimental or investigational plan by the attending provider or another provider studying the same service; or
 - a written informed consent used by the treating provider in which the service is referred to as experimental or investigational, or other than conventional or standard therapy; or
 - an ongoing clinical trial.

Or, the BCBSM medical director may rely on other information to determine whether a service is experimental or investigational, including but not limited to:

- scientific data, such as controlled studies in peer reviewed journals or medical literature;
- information from the Blue Cross and Blue Shield Association or other local or national bodies;
- information from local or national medical societies, other appropriate professional societies, organizations, committees or governmental bodies;
- approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Assessment (OHTA) and other governmental agencies;
- accepted national standards of practice in the medical profession;
- approval by the Institutional Review Board of the hospital or medical center;
- Eligible expenses for services, supplies or care not otherwise covered under your BCBSM coverage, are covered for the approved amount as determined by MESSA/BCS. In making this determination MESSA/BCS will use the following criteria:
 - the covered service, supply or care is appropriate for the symptoms and is consistent with the care, service or supply that is needed to provide safe and adequate care and treatment. Because of ongoing medical research and technological advances, services, supplies or care that have been considered investigational or experimental may become generally accepted and appropriate;
 - the service, supply or care is not mainly for the convenience of the member or provider of the service, supply or care.

22.5 How To Appeal a Claim Denial

Your Right To File An Internal Grievance and To Request An Independent External Review

Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000 (MCLA 550.1404), provides an internal grievance procedure, including a managerial-level conference, if you believe that we have violated Section 402 or 403 of Public Act 350.

Public Act 251 of 2000 (MCLA 550.1901-550.1929) provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

Internal Grievances

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

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.
 - Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

- We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.
- If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

MESSA Legal and Compliance Department

1475 Kendale Boulevard

P.O. Box 2560

East Lansing, MI 48826-2560

You can ask that the conference be conducted in person or over the telephone. Our written proposed resolution will be our final determination regarding your grievance.

If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information above, you should also know:

- you may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal grievance procedure;
- Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish;
- You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.

Expedited Internal Grievance Procedure—If a physician substantiates verbally or in writing that adhering to the timeframe for the standard internal grievance would jeopardize your life or health, or would seriously jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service **prior** to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is as follows:

- You may submit your expedited internal grievance request by telephone. The required physician’s substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.
Call: 800.742.2328
- 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 Commissioner.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure;
- If our decision is communicated to you verbally, we must provide you with written confirmation within 2 business days.

External Review

Standard External Review Procedure—Once you have exhausted our standard internal grievance procedure, you or your authorized representative have the right to request an

external review from the Commissioner. The standard external review process is as follows:

- Within 60 days of the date you either received our final determination or should have received it, send a written request for an external review to the Commissioner. Mail your request, including the required forms that we will supply to you, to:

Appeals Section
Office of Financial and Insurance Services
P.O. Box 30220
Lansing, MI 48909

- If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within 7 days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the independent review organization within 7 business days after we receive notice of your request from the Commissioner.

The assigned independent review organization will recommend within 14 days whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within 7 business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

- If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the external review.

The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision. The Commissioner's decision is your final administrative remedy under Public Act 350.

Expedited External Review Procedure—If a physician substantiates verbally or in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and if you have filed a request for an expedited internal grievance, you may request an expedited external review, from the Commissioner. **You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service.** The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination, or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Commissioner. To do so in writing, mail your request, including the required forms that we will supply to you, to:

Appeals Sections
Office of Financial and Insurance Services
P.O. Box 30220
Lansing, MI 48909
To do so by telephone, call: 877.999.6442

- Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an independent review organization to

conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination.

The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right To Independent Review Act.

22.6 Contesting a Denial

A person seeking payment by MESSA/BCBSM/BCS, directly or indirectly, will be furnished with the specific reason(s) for denial of a claim and an explanation of any additional information required from or on behalf of the member or dependent for reconsideration of the claim in accordance with MESSA/BCBSM/BCS's claim review procedure.

No action or suit at law may be commenced upon or under this plan until 30 days after notice has been given by the member or covered dependent to MESSA/BCBSM/BCS that the reconsidered decision of MESSA/BCBSM/BCS under its claim review procedure is unacceptable, nor may such action be brought at all later than 2 years after such claim has arisen.

22.7 Subrogation/Right of Recovery

From time to time, MESSA/BCBSM/BCS may pay claims for which another person or persons, insurance company, or other organization (including the covered member's employer or any Workers' Disability or Occupational Disease Act insurer) is responsible ("responsible party"). In these cases, the covered member:

- Grants to MESSA/BCBSM/BCS the covered member's right to recover from the responsible party to the extent of MESSA/BCBSM/BCS's payment. MESSA/BCBSM/BCS have entered into an agreement assigning this right to recovery to MESSA;
- Grants to MESSA/BCBSM/BCS a first priority security interest (meaning the right to be paid before any other person including the covered member) in all money that a covered member or a covered member's estate or beneficiaries recover in a verdict, judgment, settlement (regardless of whether the settlement is part of a legal action), or otherwise. Any part of the recovery that is used to pay attorney's fees and costs will not be subject to MESSA/BCBSM/BCS lien;
- Agrees to inform MESSA/BCBSM/BCS when the covered member (or a beneficiary) hires an attorney to represent the covered member or beneficiary with respect to a claim for recovery against a responsible party whether that claim is made through litigation or is asserted prior to litigation;
- Agrees to inform any attorney retained of MESSA/BCBSM/BCS's rights under this Certificate;
- Agrees to take whatever steps are necessary to assist MESSA/BCBSM/BCS in enforcing its right of recovery including but not limited to cooperating in trial preparation, discovery, and by testifying in any civil action.

If an overpayment is made by MESSA/BCBSM/BCS for any reason, including but not limited to a payment under any Workers' Disability or Occupational Disease Act or law, clerical error, or misstatement of fact, MESSA/BCBSM/BCS shall have the right to recover such overpayments from the covered member (or a beneficiary of the covered member's estate), or to deduct such amount of overpayment from future benefit payments.

22.8 Medical Examination

MESSA, at its own expense, shall have the right and opportunity to have an individual examined by a physician of its choice as often as it may reasonably require while a claim is pending under this plan.

22.9 Professional Relationship

Nothing contained in this contract will interfere with the professional relationship between you and the physician selected by you. MESSA/BCBSM/BCS does not undertake to supply a physician to you or your dependent.

22.10 Hospital Admission

You may elect the service of any hospital, but MESSA/BCBSM/BCS does not guarantee admission to any particular hospital. Service is subject to all the rules and regulations of the hospital selected, including those governing admission.

22.11 Hospital Obligation

Each participating hospital has assumed a direct obligation to you to furnish its services under this contract, subject to the terms and conditions imposed by this contract. No participating hospital has any responsibility or liability with respect to the obligation assumed by any other hospital or with respect to any care or service provided by any other participating hospital. The obligation of each participating hospital is subject to its right to withdraw as a participating hospital in the manner provided in its participating hospital agreement with BCBSM. Withdrawal terminates all obligations of the withdrawing hospital to provide any service under this contract except as provided in its agreement with BCBSM.

22.12 What Laws Apply

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

Section 23: NurseLine and Healthy Expectations

MESSA NurseLine and **Healthy Expectations** are MESSA services that provide members with 24-hour access to trained health care professionals and an audio library of medical information.

MESSA NurseLine—NurseLine is a health information line staffed around the clock by registered nurses trained to answer medical questions and offer guidance. Members can call NurseLine and speak with a registered nurse or listen to prerecorded information from an extensive audio health library. If the member chooses to speak with a nurse, a specially-trained nurse will listen to the member and discuss the health concerns. The nurse may provide some home health care measures or suggest the member contact his or her personal physician.

MESSA Healthy Expectations—Healthy Expectations provides support for expectant mothers. After enrollment in the program an expectant mother will receive a simple health assessment questionnaire to complete and return. Healthy Expectations will then send a guidebook and a customized response providing information on health guidelines for pregnant women. If any risk factors are identified, a Healthy Expectations nurse may contact the participant and offer additional assistance.

Healthy Expectations and NurseLine can be accessed by calling 800.414.2014.

Important Notes

- The *NurseLine* and *Healthy Expectations* phone line is not a 911 service and is not intended to replace qualified medical care given by your doctor or another medical professional. Members who have an illness or injury that requires immediate attention, should go directly to an emergency room;
- All inquiries to *Healthy Expectations* and *NurseLine* are strictly confidential.

Section 24: Life Benefits and Accidental Death and Dismemberment (AD&D) Benefits

Certificate—Connecticut General Life Insurance Company Hereby Certifies that Members of the Michigan Education Special Services Association (Called The Policy Holder) who are insured under Group Policy No. 57200 are subject to the terms and conditions of this policy and are insured for the benefits described in the pages of this booklet.

Connecticut General Life Insurance Company, called Connecticut General, insures the life and accidental death and dismemberment benefits. Connecticut General will determine all benefit payments according to the provisions described in the booklet and the group policy.

The insurance is effective only if the person concerned is eligible, becomes covered and remains covered, in accordance with the terms and conditions of the policy. Coverage applies to members only, as defined on page 1. Dependents are not eligible for either the life insurance or accidental death and dismemberment insurance benefits.

The certificate replaces any other certificate issued to you describing these benefits.

—**Connecticut General Life Insurance Company** (PF75134 amended by PF33333)

General Provisions—The following will explain the life and AD&D benefits available to you under the MESSA Super Care 1 2003 Revision plan.

24.1 Beneficiary

The beneficiary for your life and AD&D insurance for loss of life will be the person you name as shown in the records kept on the group insurance policy. If there is no named beneficiary living at your death, a lump sum will be paid to the first surviving class that follows:

- spouse;
- children;
- parents;
- brothers and sisters.

If none survives, the benefit will be paid to your estate in a lump sum.

If the beneficiary is a minor with no legal guardian, the minor's share may be paid to the adult (or adults) who, in Connecticut General's opinion, have assumed custody and support of the minor. Payment may be made at a rate of up to \$50 a month.

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy.

24.2 Assignment of Life Insurance

There is only one assignment of your life insurance that is valid. The assignment which:

- states that it is without consideration;

- is made to a named beneficiary;
- is in writing; and
- is accepted by Connecticut General.

The assignment may be made without the consent of the beneficiary.

Once an assignment is accepted and while it remains in force, the assignee can exercise any of the rights and privileges under the group policy granted to you (including but not limited to, the conversion privilege), and becomes entitled to receive all claim payments under the insurance assigned with respect to which no beneficiary is designated by the assignee, unless the group policy states differently.

Acceptance of an assignment by Connecticut General shall be without further liability as to any action or any payment or other settlement made by Connecticut General before such acceptance. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

24.3 Life Insurance Benefits

The following information will explain your life insurance benefits under the Super Care 1 2003 Revision plan.

How Payment is Made—If you die while covered under the Super Care 1 2003 Revision plan, Connecticut General will pay your beneficiary \$5,000. You may choose to have the benefit paid in a lump sum or in installments. You may also change your beneficiary or the method of payment at any time. Contact MESSA Group Services for the appropriate forms.

After your death, your beneficiary may choose the method of payment (if you have not already done so) and name a person to receive the benefit amount which would be paid to the beneficiary's estate in the event your beneficiary died before payment was made.

24.4 Continuation of Life Insurance Coverage

While Disabled—If you become totally disabled by injury or disease and you are not able to perform any work for which you are reasonably qualified by learning or experience, your group life insurance coverage will continue for one year from the date the total disability is approved by Connecticut General. You will continue to be covered for a benefit of \$5,000.

To be eligible for this **extended coverage**, you must be under 65 years old when you become disabled, and you must remain totally disabled during the year-long period.

Note: If you remain disabled, your contributions will be waived and your coverage will continue. To minimize the financial burden during your disability, your contributions towards life insurance will be waived.

Your contributions will be waived on the date that Connecticut General receives satisfactory proof of your disability—but no earlier than six months after the onset of the disability. If you remain disabled after the first year of continued benefits, your coverage will continue without any contributions from you as long as you provide Connecticut General with proof of the disability annually, within the three-month period prior to the anniversary of the date the total disability was approved.

If you converted to an individual life insurance policy while you were disabled, you must return the individual policy to Connecticut General with your first proof of total disability. Connecticut General will refund any contributions you made for the individual policy.

Connecticut General maintains the right to have its medical representative examine you to verify the disability, but will not do so more than once a year after your extended coverage

has continued for more than two years. There is no cost to you for medical exams requested by Connecticut General.

If You Die While Disabled—If you die while you are still disabled, your beneficiary will receive the life insurance benefit as soon as proof of your continued disability is received by Connecticut General.

If you die after you have converted your policy, any amount paid under the individual policy will be deducted from the amount due under the group life insurance policy and any contributions to the individual policy will be refunded to your beneficiary when the policy is returned.

When Your Extended Coverage Ends—Your extended coverage will end if you:

- cease to be totally disabled;
- fail to give required proof of your disability;
- fail to submit to a medical exam.

When your extended coverage ends, you can convert to an individual policy under the same conditions that would apply if you left school employment. See “After Employment Ends” below.

After Employment Ends—You have 31 days to convert to an individual policy and pay your first contribution. You won’t need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be limited in your choice of policy. The individual policy amount must be no greater than \$5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

If you have merely changed job classification, and are eligible for coverage under another group policy, the amount of your converted individual policy will be reduced by the amount of that group policy.

The individual policy will take effect 31 days after coverage under the group policy ends. Should you die in that period without converting, Connecticut General will pay your beneficiary the amount you could have converted.

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance. MESSA will mail you a continuation notice for electing this option upon termination of your employment.

After your Employer Terminates Participation in the Group Policy or Coverage for Your Job Classification Ends—Again, you have 31 days to convert to an individual policy. The same conditions apply as if your employment ended. In addition, you must have been insured by the group policy for at least five years in a row.

The maximum amount of life insurance you may convert is \$2,000, less any amount you became eligible for under any other group policy during the 31-day conversion period.

Should you die in the 31-day period after your participation ends, or after the group policy itself terminates, and you were insured by the group policy for the preceding five years, you are still covered. Connecticut General will pay your beneficiary the group life insurance policy amount, less the amount of any other group policy under which you became insured during that 31-day conversion period without converting, the amount you could have converted.

Even if you should die within the 31-day conversion period without converting, Connecticut General will still pay your beneficiary the amount you could have converted.

24.5 Accidental Death And Dismemberment (AD&D) Benefits

The following information will explain your AD&D benefits under the Super Care 1 2003 Revision plan.

What is Covered—As a MESSA member you have \$5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, Connecticut General will pay according to the schedule listed under “How AD&D Benefits Are Paid.”

In order to receive an AD&D benefit, the loss must:

- be caused exclusively by external and accidental means;
- be the direct result of the injury, independent of all other causes;
- occur within 180 days from the date of the injury.

All benefits other than loss of life will be paid to you. If you die, the benefits will be paid to your beneficiary. See Page 34 for details about your beneficiary.

You may change your beneficiary at any time. Contact MESSA Group Services at 800.292.4910 for the appropriate forms.

How AD&D Benefits Are Paid

For the Loss of:

- Life; or
- Both hands or both feet; or
- Sight in both eyes; or
- Any two or more: foot
 hand
 eye

You Receive:

100% of AD&D Benefit (\$5,000)

For the Loss of:

- One hand; or
- One foot; or
- Sight in one eye; or
- Speech; or
- Hearing.

You Receive:

50% of AD&D Benefit (\$2,500)

For the Loss of:

- Thumb and index finger
 on the same hand.

You Receive:

25% of AD&D Benefit (\$1,250)

The following defines what is considered a loss:

Term

Definition

Loss of hand or foot

Loss by cutting off at or above the wrist or ankle joint

Loss of sight, speech, or hearing

Total loss that cannot be recovered

Loss of thumb and index finger

Loss by cutting off at the proximal phalangeal joint

When You Suffer More Than One Loss—If you have more than one loss due to one accident, you will receive payment only for the loss with the largest benefit payout. You will only be paid for the loss resulting from the accident in question, regardless of any previous loss.

Losses Not Covered—No benefits will be paid for losses resulting from, or caused directly or indirectly by:

- bodily or mental infirmity;
- disease or illness of any kind;
- self-destruction or intentionally self-inflicted injury;

- taking part in an insurrection or riot; war or act of war; service in any military or naval organization, unless the injuries are sustained while off-duty;
- taking part in, or as a result of taking part in, a felony.

When Coverage Ends—AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. If your school employment ends before you reach age 65, you must pay the required contribution for the cost of this insurance to continue this coverage until you reach age 65.

How to File a Life or AD&D Claim

24.6 Life Claims

Contact MESSA Group Services at 800.292.4910 for the forms necessary to file a life insurance claim.

24.7 AD&D Claims

Contact MESSA Group Services at 800.292.4910 for the forms necessary to file an AD&D claim. AD&D claims are subject to the following:

Filing Deadline—Written notice of the event upon which the claim is based must be given within 20 days after the loss covered by the policy occurs or begins or as soon after that time as is reasonably possible.

Notice—Notice must be given by, or on behalf of, the claimant to:

- Connecticut General; or
- MESSA; or
- any other authorized representative of Connecticut General.

The notice must include sufficient information to identify you.

Claim Forms—On receipt of a notice of a claim, Connecticut General or MESSA will give the claimant forms for filing proof of loss. If such forms have not been furnished within 15 days after the giving of the notice, the claimant can fulfill the terms of the policy as to proof of loss by giving written proof of:

- the occurrence of the loss;
- the nature of the loss;
- the extent of the loss.

The proof of loss must be given within the time stated in “Proof of Loss” below.

Proof of Loss—Written proof of the loss must be given to Connecticut General within 90 days after:

- the date of the loss; or
- the end of the period for which Connecticut General is liable.

Late proof will be accepted only if it is furnished as soon as is reasonably possible. In no event, except in the absence of your legal capacity, will proof be accepted later than one year from the time proof would otherwise have been required. Itemized bills may be required as proof of loss.

Time of Payment of Claims—Benefits are payable upon receipt of due proof of loss.

Payment of Claims—Benefits for loss of life will be paid in accordance with the beneficiary named by you, if any, and the terms of the policy in effect at the time payment is made.

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Any other accrued benefits not paid at your death may, at the option of

Connecticut General, be paid either to such beneficiary or your estate. Accidental dismemberment benefits will be payable to you.

If any benefit of the policy is payable to your estate, to you or your beneficiary while a minor, or to you or your beneficiary while not competent to give a valid release, Connecticut General may pay such benefit, up to \$1,000, to anyone related by blood or by marriage to you or the beneficiary, and deemed by Connecticut General to be justly entitled. Any such payment made in good faith will discharge Connecticut General to the extent of such payment.

Physical Examination and Autopsy—At its own expense, Connecticut General has the right to have a doctor examine any person when it deems reasonably necessary and there is a claim pending under the policy. Connecticut General also has the right to make an autopsy in the case of death unless the law forbids it.

Legal Actions—No one may sue for payment of a claim less than 60 days after proof of loss is furnished in accord with the terms of the policy. No one may bring suit more than three years after the date proof of loss is required by the policy.

Time Limit on Certain Defenses—A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

- the insurance has been in force for at least two years before any such contest; and
- the person with respect to whom any such statement was made was alive during those two years.

Change of Beneficiary—You may change your beneficiary at any time. You do not need the consent of your beneficiary to make such change.

Contact MESSA Group Services at 800.292.4910 with any life insurance or AD&D claim questions.

Section 25: Definitions

Words used in this booklet have the following meanings:

Accidental Injury—one that occurs as the result of a traumatic bodily injury, such as a strain, sprain, abrasion or contusion, or cut, as well as other conditions such as, but not limited to: swallowing poison or an overdose of medication whether accidentally or on purpose, allergic reactions from contact dermatitis, bee stings or insect bites, breathing smoke, carbon monoxide or fumes, burns, frostbite, sunburn, sunstroke, or attempted suicide.

Allogeneic (Allogenic) Transplant—a procedure using another person’s bone marrow, peripheral blood stem cells or umbilical cord blood to transplant into the patient. This includes syngeneic transplants.

Ambulance Service—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.

Ambulatory Surgery—elective surgery that does not require use of extensive hospital facilities and support services, but is not usually performed in a physician’s office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility—a freestanding outpatient surgical facility offering surgery and related care that can be safely performed without needing overnight inpatient hospital care. It does not include an office of a physician or other private practice office.

Approved Amount—the lower of the billed charge or the BCBSM maximum payment level for the covered service. Co-payments or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Substance Abuse Treatment Program—a residential or outpatient program that provides medical and other services for substance abusers, and meets all state licensure and approval requirements.

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

BCS—BCS Life Insurance Company

Benefit—the payment we make for covered services.

BlueCard Participating Provider—a provider who participates with the Host Plan.

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

Certified Nurse Practitioner—a nurse who provides some medical services and who:

- is licensed as a registered nurse by the state of Michigan;
- has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing;
- meets BCBSM qualification standards.

Certified Registered Nurse Anesthetist—a nurse who provides anesthesia 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 BCBSM qualification standards.

Colony Stimulating Growth Factors—factors that stimulate the multiplication of very young blood cells.

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

Custodial Care or Domiciliary Care—the provision of room and board—with or without routine nursing care, training in personal hygiene and other forms of self-care, or supervisory care by a physician—for a person who is not under specific medical, surgical, or psychiatric treatment to reduce a disability to the extent necessary to enable that person to live outside an institution providing medical care.

Designated Payment Level—the amount used to calculate your BCBSM co-payment under the BlueCard Program. This amount is the lesser of:

- the provider’s billed charges for covered services; or
- an amount based on such factors as agreements with the Host Plan’s provider community or historical average reimbursement levels.

Note: BlueCard Program policies permit Host Plans to adjust negotiated prices going forward to correct for overestimation or underestimation of past prices. However, the designated payment level used to calculate your BCBSM co-payment is considered a final price.

Some state laws require that a special calculation be applied to determine the Host Plan's payment. In such instances, the designated payment level will reflect any statutory requirements in effect at the time you receive care.

Drugs and Biologicals—medicinal agents that are approved for commercial distribution by the Federal Food and Drug Administration.

Dual Entitlement—when an individual is entitled to Medicare on the basis of both ESRD and age or disability.

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

Effective Date—the date on which coverage begins under this contract.

End Stage Renal Disease (ESRD)—permanent kidney failure that requires a regular course of dialysis or a kidney transplant, as verified by a medical evidence report (see definition of medical evidence report in this section) or a provider bill that contains a diagnosis of chronic renal failure.

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

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

Experimental or Investigational—a service, procedure, treatment, device, drug, or supply, that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition.

First Degree Relative—an immediate family member; that is, a mother, father, sister or brother.

Freestanding Outpatient Physical Therapy Facility—a facility, separate from a hospital, that provides outpatient physical therapy services and meets all local and state licensure and certification requirements.

Hemodialysis—the treatment of chronic, irreversible kidney disease by use of a dialysis machine to purify the blood mechanically.

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 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—a centrally administered public or private agency or organization, or a subdivision thereof, that is primarily engaged in providing physician-directed skilled nursing and other paramedical or therapeutic devices to patients at home. A home health care agency must meet all local and state licensure and certification requirements. It does not include an agency that is engaged primarily in the care and treatment of mental disease or disorder.

Hospice—a licensed public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals.

Hospital—a facility that:

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

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

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

- *facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care;*
- *facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers;*
- *skilled nursing facilities or other nursing care facilities.*

Host Plan—a Blue Cross of Blue Shield Plan outside of Michigan that participates in the BlueCard Program and processes claims for services that you receive in that state.

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

Medically Necessary—the service provided meets the requirements listed below for payment of physician services or payment of hospital services:

- **Medical necessity for payment of physician services:** A determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:
 - the covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
 - in the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

Note: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

- **Medical necessity for payment of hospital services:** A determination that allows for the payment of hospital services when *all* of the following conditions are met:
 - the covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease;
 - the service, treatment, or supply is *appropriate* for the symptoms and is consistent with the diagnosis. *Appropriate* means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment. For inpatient hospital stays, acute care as an inpatient must be

necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

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

Medicare—the federal program created by Title XVIII of Public Law 89-97, as amended. It includes Part A (Hospital Insurance Benefits for the Aged and Disabled) and Part B (Supplementary Medical Insurance Benefits for the Aged and Disabled).

Member—an individual who is a member of MESSA.

Mental Disorder—any mental, emotional or personality disorder classified as a mental disorder in the most recent edition of the *International Classification of Diseases*.

MESSA—the Michigan Education Special Services Association

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

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

Orthopedic Shoes—types of footwear prescribed by physicians as a sequel to professional medical treatment of conditions such as club feet, foot flare or outflare and limb length discrepancies. Covered items include custom fabricated shoes, shoe inserts, and arch supports, Thomas heels, shoes attached to braces, and alterations to orthopedic shoes.

Orthoptics—the treatment of defective visual habits and defects of binocular vision.

Orthotic Appliance—an external device intended to correct any defect of form and function of the human body.

Outpatient Mental Health Facility—an administratively distinct public, private or independent unit or part of such unit that provides outpatient mental health services. The term includes centers for the care of adults or children, 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 or alcohol abusers on an outpatient basis at a licensed facility.

Peripheral Blood Stem Cell Transplant—a procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.

Peritoneal Dialysis—the removal of toxic substances from the body by perfusion of chemical solutions through the abdomen. *Pheresis* is the removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Therapy—the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function 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;
- joint motion;
- coordination;
- general mobility.

Physician—a doctor of medicine (MD) or osteopathy (DO) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, dentist, podiatrist or a doctor of chiropractic 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 that he/she is legally qualified to perform.

A physician is also a person who is licensed under Public Act 368 Public Acts of Michigan 1978, starting at MCLA 333.17011, 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.

Pre-Existing Condition—a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.

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

Prosthetic Appliance—an artificial device that replaces an absent part of the body or aids the performance of a natural function of the body without replacing a missing part.

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

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

Qualifying Event—one of the following events that allows a qualified beneficiary to receive COBRA coverage:

- termination of employment, other than for gross misconduct, or reduction of hours;
- death of the employee;
- divorce;
- loss of dependent status due to age, marriage, change in student status, etc.;
- the employee becomes entitled to coverage under Medicare.

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.

Residential Substance Abuse Treatment Program—a program that provides medical and other services specifically for substance abusers in a licensed facility that operates twenty-four (24) hours a day, seven (7) days a week.

Secondary Plan—the health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training—teaching a member to conduct dialysis on himself or herself.

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

Semiprivate Room—a room containing two beds.

Skilled Nursing Facility—a facility providing convalescent and short or long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet all applicable local and state licensure and certification requirements.

Special Care Unit—a designated unit within a hospital (such as a cardiac care, burn care, or intensive care unit) that concentrates all necessary types of equipment together with skilled nursing and supportive services needed for care of critically ill patients.

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 components including red cells, white cells and platelets.

Substance Abuse—the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs and constitutes alcohol or drug dependence as classified in categories 303-304.9 of the most current edition of the *International Classification of Disease*.

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

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

T-Cell Depleted Infusion—a procedure in which T-cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Terminally Ill—a medical prognosis that an individual's life expectancy is six months or less.

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.

Valid Application—an application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Waiting Period—defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the third month after the month in which the regular course of dialysis begins, provided the member files a valid application for Medicare benefits.

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

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



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