

## **Blue Care Network Certificate of Coverage High Deductible Health Plan For Individuals**

This Certificate of Coverage (Certificate) is part of the contract between you and Blue Care Network of Michigan (BCN).

This Certificate describes the Benefits provided under your Coverage. It includes General Provisions, and Your Benefits

This High Deductible Health Plan (HDHP) is a non-group product of BCN, an independent corporation operating under a license from the Blue Cross® Blue Shield Association®. This association is made up of independent Blue Cross® Blue Shield® plans. This Association permits BCN to use the Blue Cross® Blue Shield® Service Marks in Michigan.

When you enroll, you understand that:

- BCN is not contracting as the agent of the Association.
- You have not entered into the contract with BCN based on representations by any person other than BCN.
- No person, entity or organization other than BCN will be held accountable or liable to you for any of BCN's obligations created under the contract.
- There are no additional obligations on the part of BCN other than those obligations stated under the provisions of the contract with BCN.

BCN is a Health Maintenance Organization (HMO) licensed by the state of Michigan and affiliated with Blue Cross® Blue Shield® of Michigan.

This Certificate and any attached Riders are issued by BCN and is a contract between you, as an enrolled Member and BCN.

By choosing to enroll as a BCN Member, you, agree to abide by the rules as stated in the General Provisions and Your Benefits chapters. You also recognize that, except for Emergency health services, only the health care services provided by your Primary Care Physician or arranged and approved by BCN are covered under this Certificate. You are entitled to the Benefits as described in this Certificate in exchange for the premium paid to BCN.

BCN does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determination.

### [IMPORTANT HEALTH SAVINGS ACCOUNT INFORMATION](#)

This HDHP is a health plan that contains certain requirements set by the Internal Revenue Service with respect to Deductible amount and Out-of-Pocket limits. A qualifying HDHP has a minimum annual Deductible and maximum Out-of-Pocket limits. The HDHP does not offer

Copayments and Coinsurance for pharmacy and medical services prior to satisfying the annual Deductible.

You must be covered by a HDHP if you want to open a Health Savings Account (HSA).

You have the option to open a Health Savings Account (HSA) if you have a HDHP, you have no other coverage (except limited purpose coverage) and you are not enrolled in Medicare.

**NOTE:** You cannot establish and contribute to an HSA unless you have Coverage under a HDHP. Your HSA money can be used to help pay your Deductible, Copayments, Coinsurance and Qualified Medical Expenses not covered by this Plan.

Only services incurred after you establish your HSA are considered Qualified Medical Expenses. Expenses incurred before you establish your HSA are not considered Qualified Medical Expenses.

It is your responsibility to keep track of your HSA deposits and expenditures and keep all of your explanation of payments and receipts.

If you have questions about this Coverage, contact BCN Customer Service Department.

BCN Customer Service  
P.O. Box 68767  
Grand Rapids, MI 49516-8767  
Or  
Blue Care Network  
20500 Civic Center Drive  
Southfield, MI 48076  
800-662-6667  
bcbsm.com

**Blue Care Network 10-Day Money-Back Guarantee**

BCN is committed to the health and satisfaction of our Members. If for any reason, you are unsatisfied and wish to terminate your Coverage, simply notify us in writing within 10-days of the effective date of your Coverage. You will receive a full refund of your premium. If you terminate your Coverage after 10-days, you will receive a pro-rated refund on the unused portion of your premium. Please see above for our mailing address and telephone number.

## Definitions

These definitions will help you understand the terms that we use in this Certificate. They apply to the entire Certificate. More terms may be defined in subsequent sections of this Certificate. In addition to these terms, use of terms “we”, “us” and “our” refer to BCN. The terms “you” or “your” refer to the Member, which may be enrolled with BCN as either a Subscriber or Family Dependent.

**Acute Care or Service** is medical care that requires a wide range of medical, surgical, obstetrical and or pediatric services. It generally requires a Hospital stay of less than 30 days.

**Acute Illness or Injury** is one that is characterized by sudden onset (e.g. following an injury) or presents an exacerbation of a disease and is expected to last a short period of time after treatment by medical or surgical intervention.

**Approved Amount also known as the Allowed Amount** is the lower of the billed charge or the maximum amount BCN will pay for the Covered Service. Any Cost Sharing that you may owe is subtracted from the Approved Amount before we make our payment.

**Assertive Community Treatment** is a service-delivery model that provides intensive, locally based treatment to people with serious persistent mental illnesses.

**Balance Billing** (sometimes also called extra billing) is when a provider bills you for the difference between the provider’s charge and the Approved Amount. A BCN Participating Provider may not balance bill you for Covered Services.

**Benefit** is covered health care service as described in this Certificate.

**BlueCard Program** is a program that, subject to Blue Cross® and Blue Shield® Association policies and the rules set forth in this Certificate, allows BCN to process claims incurred in other states through the applicable Blue Cross and Blue Shield Plan.

**Blue Care Network (BCN)** is the Michigan health maintenance organization in which you are enrolled.

**Calendar Year** is a period of time beginning January 1 and ending December 31 of the same year.

**Certificate or Certificate of Coverage** is this legal document that describes the rights and responsibilities of both you and BCN. It includes any Riders that may be attached to this document.

**Chronic** is a disease or ailment that is not temporary or recurs frequently. Arthritis, heart disease, major depression and schizophrenia are examples of Chronic diseases.

**Coinsurance** is your share of the costs of a Covered Service calculated as a percentage of the BCN Approved Amount that you owe after you pay any Deductible. We pay the remainder of the Allowed Amount. Your Coinsurance is added or amended when a Rider is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

**Continuity of Care** refers to a Member's right to choose, in certain circumstances, to continue receiving services from a physician who ends participation with BCN. (See Section 8)

**Coordination of Benefits (COB)** means a process for determining which certificate or policy is responsible for paying first for Covered Services (primary carrier) when you have coverage under more than one policy. Benefit payments are coordinated between the two carriers to provide 100% coverage whenever possible for services covered in whole or in part under either plan, but not to pay in excess of 100% of the total allowable amount to which providers or you are entitled.

**Copayment (Copay)** is a fixed dollar amount you owe for certain Covered Services usually when you receive the service. A Copay can be added or amended when a Rider is attached. Copay amounts might be different for different health care services. For example, your Emergency room Copay might be higher than your office visit Copay. Copays apply to the Out-of-Pocket Maximum.

**Cost Sharing (Deductible, Copayment and/or Coinsurance)** is the portion of health care costs you owe as defined in this Certificate and attached Riders. We pay the rest of the Allowed Amount for Covered Services.

**Covered Services or Coverage** refers to those Medically Necessary services, drugs, or supplies provided in accordance with and identified as payable under the terms of the Certificate.

**Custodial Care** is care primarily used to help the Member with activities of daily living or meet personal needs. Such care includes help walking, getting in and out of bed, bathing, cooking, cleaning, dressing and taking medicine. Custodial Care can be provided safely and reasonably by people without professional skills or training. Custodial Care is not covered.

**Deductible** is the amount that you owe for covered medical and prescription drug expenses before we pay. Your Deductible is based on amounts defined annually by the federal government for Health Savings Account related health plans. The Deductible applies to your Out-of-Pocket Maximum. Your Deductible amount may be added or amended when a Rider is attached.

**Dependent Child** is an eligible individual under the age of 26 who is the son or daughter in relation to the Subscriber or spouse by birth, legal adoption or for whom the Subscriber or spouse has legal guardianship. NOTE: A Principally Supported Child is not a Dependent Child for purposes of this Certificate. (See definition of Principally Supported Child below.)

**Elective Abortion** means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Elective abortion does not include any of the following:

- The use or prescription of a drug or device intended as a contraceptive;
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's

reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death; or

- Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

**Emergency Medical Condition** is an illness, injury or symptoms that require immediate medical attention to avoid permanent damage, severe harm or loss of life. (See Section 8 Emergency and Urgent Care)

**Enrollment** is the process of submitting a completed enrollment form and paying the necessary premium to BCN to receive Coverage.

**Facility** is a Hospital, clinic, freestanding center, urgent care center, dialysis center, etc. that provides specialized treatments devoted primarily to the diagnosis, treatment care and /or rehabilitation due to illness or injury.

**Family Dependent** is an eligible family member who is enrolled with BCN for health care Coverage. A Family Dependent includes Dependent Children and a Dependent under a Qualified Medical Child Support Order, but does not include a Principally Supported Child. Family Dependents must meet the requirements stated in the General Provisions, Section 1.

**General Provisions** is Chapter 1 that describes the rules of your health care Coverage.

**Grievance** is a written dispute about coverage determination or quality of care that you submit to us. For a more detailed description of the grievance process, refer to section 3.5.

**Habilitative services/devices** are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (Habilitative Services). Examples include therapy for a child who is not walking or talking at an expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health Savings Account (HSA)** is a tax-favored trust or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain Qualified Medical Expenses you incur. You must be covered by a High Deductible Health Plan (HDHP) to take advantage of an HSA.

**High Deductible Health Plan (HDHP)** is a health plan with a minimum annual Deductible and Out-of-Pocket Maximum. These minimum and maximums are determined annually by the Internal Revenue Service and are subject to change. HDHP requires Members to pay for all Covered Services, except preventive care services, until the Deductible is met.

**Hospital** is a Participating, acute-care Facility that provides continuous, 24-hour Inpatient medical, surgical or obstetrical care. The term "Hospital" does not include a Facility that is primarily a nursing care Facility, rest home, home for the aged or a Facility to treat substance abuse, psychiatric disorders or pulmonary tuberculosis.

**Inpatient** is a Hospital admission where you occupy a Hospital bed while receiving Hospital care including room and board and general nursing care and may occur after a period of Observation Care.

**Medical Director** (when used in this document) means BCN's Chief Medical Officer ("CMO") or a designated representative.

**Medical Necessity or Medically Necessary** services are health care services provided to the Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are:

- Rendered in accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease;
- Not primarily for the convenience of the Member or health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease;
- Not regarded as experimental by BCN; and
- Rendered in accordance with BCN Utilization Management Criteria for Mental Health and Substance Abuse Disorders.

**Member** (or you) means the individual entitled to Benefits under this Certificate.

**Mental Health Provider** is duly licensed and qualified to provide mental health services in a Hospital or other facility in the state where treatment is received. Mental health services require preauthorization.

**Non-Participating or Non-Participating Provider** means an individual Provider, Facility or other health care entity not under contract with BCN. Unless the specific service is Preauthorized as required under this Certificate, the service will not be payable by BCN. You may be billed directly by the Non-Participating Provider and will be responsible for the entire cost of the service.

**Observation Care** consists of clinically appropriate services that include testing and/or treatment, assessment, and reassessment provided before a decision can be made whether you will require further services in the Hospital as an Inpatient admission, or may be safely discharged from the Hospital setting. Your care may be considered Observation Hospital care even if you spend the night in the Hospital.

**Open Enrollment Period** is a period of time set each year by BCN when you can enroll or disenroll in BCN.

**Out-of-Pocket Maximum** is the most you have to pay for Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your medical and pharmacy Deductible, Copayment and Coinsurance. This limit never includes your premium, Balance Billed charges or

health care that we do not cover. Your Out-of-Pocket Maximum amount may be amended when a Rider is attached.

**Participating or Participating Provider means** an individual Provider, Facility or other health care entity that is contracted with BCN to provide you with Covered Services. The Participating Provider agrees not to seek payment from you for Covered Services except for permissible Deductible, Copayments and Coinsurance.

**PCP Referral** is the process by which the Primary Care Physician (PCP) directs you to a Referral Physician (Specialist) prior to a specified service or treatment plan. The PCP coordinates the Referral and any necessary BCN Preauthorization.

**Preauthorization, Prior Authorization or Preauthorized Service** is health care Coverage that is authorized or approved by your Primary Care Physician (PCP) and/or BCN prior to obtaining the care or service. Emergency services do not require Preauthorization. Preauthorization is not a guarantee of payment. Services and supplies requiring Preauthorization may change as new technology and standards of care emerge. Current information regarding services that require Preauthorization is available by calling Customer Service.

**Premium** is the amount prepaid monthly for health care Coverage.

**Preventive Care** is care designed to maintain health and prevent disease. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

**Primary Care Physician (PCP)** is the Participating Provider you choose to provide and coordinate all of your medical health care, including specialty and Hospital care. The Primary Care Physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

**Principally Supported Child** is an individual less than 26 years of age for whom principal financial support is provided by the Subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for Coverage. A Principally Supported Child must meet the requirements in Section I. NOTE: A Principally Supported Child is not the same as a Dependent Child.

**Professional Services** are services performed by a licensed practitioner including but not limited to practitioners with the following licenses:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathic Medicine (D.O.)
- Doctor of Podiatric Medicine (D.P.M.)
- Licensed psychologist (L.P.)

- Licensed Professional Counselor (L.P.C.)
- Licensed Master Social Worker (L.M.S.W.)
- Certified Nurse Midwife (C.N.M.)
- Board Certified Behavior Analyst (B.C.B.A.)
- Doctor of Chiropractic (D.C.)
- Physician Assistant (P.A.)
- Nurse Practitioner (N.P.)

**Referral Physician** is a provider you are referred to by your Primary Care Physician.

**Rehabilitation Services** are health care services that help a person keep, get back or improve skills and functions for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation services in a variety of Inpatient and/or Outpatient settings.

**Rescission** is the retroactive termination of a contract due to fraud or intentional misrepresentation of material fact.

**Respite Care** is temporary care provided in a nursing home, hospice Inpatient Facility, or Hospital so that a family member, friend or caregiver can rest or take some time off from caring for you.

**Rider** is an amendment to the Certificate that describes any changes (addition, modifications, deletion or revision) to Coverage. A Rider applies a Copayment, Deductible and/or Coinsurance and Out-of-Pocket Maximum to select Covered Services. When there is a conflict between the Certificate and a Rider, the Rider shall control over the Certificate.

**Routine** means non-urgent, non-emergent, non-symptomatic medical care provided for the purpose of disease prevention.

**Service** is any surgery, care, treatment, supplies, devices, drugs or equipment given by a healthcare provider to diagnose or treat disease, injury, condition or pregnancy.

**Service Area** is the geographic area made up of counties or parts of counties, where we are authorized by the state of Michigan to market and sell our health plans. . The majority of our Participating Providers are located in the Service Area.

**Skilled Care** means services that

- Require the skills of qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists and speech pathologists, and/or must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the Member and to achieve medically desired result

- Are ordered by the attending physician
- Are Medically Necessary according to generally accepted medical standards  
Examples include but are not limited to: intravenous medication (including administration), complex wound care and rehabilitation services. Skilled care does not include private duty or hourly nursing, respite care, or other supportive or personal care services such as administration or routine medications, eye drops and ointments.

**Skilled Nursing Facility** is a state-licensed and certified nursing home that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

**Subscriber** is the eligible person who has enrolled with Blue Care Network. This person is responsible for payment of Coverage premiums. This person is referred to as the “Member”.  
**NOTE:** See Section 1 for eligibility requirements.

**Urgent Care Center** is a Facility that provides Covered Services that are a result of an unforeseen sickness, illness or injury, or the onset of Acute or severe symptoms. An Urgent Care Center is not the same as a Hospital emergency department or doctors’ offices.

**Your Benefits** is Chapter 2. It has a detailed description of health care Coverage including exclusions and limitations.

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## CHAPTER 1 - GENERAL PROVISIONS

### SECTION 1: Eligibility, Enrollment, and Effective Date of Coverage

This section describes eligibility, enrollment and effective date of Coverage. .

You must meet eligibility requirements set by BCN. Certain requirements depend on whether the Member is a:

- Subscriber
- Family Dependent
- Dependent under a Qualified Medical Child Support Order
- Principally Supported Child

NOTE: If more than one child is in a family, each must have his or her own contract and be named as the Subscriber.

All Members must live in the BCN Service Area unless stated otherwise in this chapter.

#### 1.1 **Subscribers**

##### **Eligibility**

You are eligible for Coverage under this Certificate if:

- You are a resident of Michigan and a U.S. citizen or legally present and live in Michigan at least 180 days per year; and
- Are not enrolled in or eligible for Medicare

NOTE to persons who become eligible for Medicare coverage after enrolling in this Certificate:

This Certificate is not a Medicare supplemental certificate. It is not intended to fill the gaps in Medicare Coverage and it may duplicate some Medicare benefits. If you are eligible for Medicare, consider switching your coverage to Medicare supplemental. Be sure you understand what this Certificate covers, what it does not cover and whether it duplicates coverage you have under Medicare.

If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this Certificate.

##### **Enrollment**

When you can enroll

- During the annual Open Enrollment Period
- At any other time due to qualifying event, including but not limited to,
  - A birth

- A change in marital status
- Loss of a job
- Loss of group coverage
- At other times of the year as allowed by federal law

### **Effective Date**

The effective date is established by BCN based on when your enrollment form is received and processed.

## **1.2 Family Dependents**

### **Eligibility**

A Family Dependent may be

- Be the legally married spouse of the Subscriber
- A Dependent Child – Subscriber’s child including natural child, step child, legally adopted child or child placed for adoption
- A Dependent under a Qualified Medical Child Support Order

Dependent Children and a Dependent under a Qualified Medical Child Support Order are eligible for Coverage until he or she turns 26. The child’s BCN membership terminates at the end of the Calendar Year in which he or she turns 26.

**Exception:** An unmarried Dependent Child and a Dependent under a Qualified Medical Child Support Order who becomes 26 while enrolled in Coverage and who is totally and permanently disabled may continue Coverage if:

- The child is incapable of self-sustaining employment because of developmental disability or physical handicap
- The child relies primarily on the Subscriber for financial support
- The child lives in the Service Area
- The disability began before their 26<sup>th</sup> birthday

Physician certification, verifying the child’s disability and that it occurred prior to the child’s 26th birthday, must be submitted to BCN within 60 days of the end of the Calendar Year in which the child turns 26

If the disabled child is entitled to Medicare benefits, BCN must be notified of Medicare coverage in order to coordinate Member benefits.

NOTE: A Dependent Child whose only disability is a learning disability or substance abuse does not qualify for health care coverage under this exception.

### **Enrollment**

When you can add Eligible Family Dependents to the Subscriber’s contract

- During the annual Open Enrollment Period
- When the Subscriber enrolls

- Within 60 days of a “qualifying event,” that is, marriage, placement for adoption, qualified medical child support order. NOTE: See below for additional requirements for Dependents under a Qualified Medical Child Support Order
- Within 31 days of the birth of the Subscriber's newborn child. NOTE: Coverage includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for the first 31 days from birth even if you do not submit an Enrollment Form. If you want the newborn's Coverage to continue beyond the first 31-day period, the Enrollment Form must be submitted to us within 31 days after the child is born.

If the eligible Family Dependents were not enrolled because of other coverage, and they lose their coverage, the Subscriber may add them within 60 days of their loss of coverage with supporting documentation.

NOTE: Other non-enrolled eligible Family Dependents may also be added at the same time as the newly qualified Family Dependent.

### ***Effective Date of Coverage – other than Dependent Under a Qualified Medical Child Support Order***

- Coverage is effective on the date of the qualifying event, if the Family Dependent is enrolled within 60 days of the event.
- If the Family Dependent is not enrolled within 60 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- For a Family Dependent who lost coverage and notifies BCN within 60 days, Coverage will be effective when the previous coverage lapsed. If you do not notify BCN within 60 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- Adopted children are eligible for Coverage from the date of placement.

NOTE: Placement means when the Subscriber becomes totally responsible for the child; therefore, the child's Coverage may begin before the child lives in the Subscriber's home.

### ***1.3 Dependent under a Qualified Medical Child Support Order Eligibility***

The child will be enrolled under a Qualified Medical Child Support Order if the Subscriber is under court or administrative order that makes the Subscriber legally responsible to provide Coverage.

NOTE: A copy of the court order, court-approved settlement agreement or divorce decree is required to enroll the child. If you have questions about whether an order is “qualified” for purposes of State law, call Customer Service at the number provided on the back of your BCN ID card or refer to Section 7 Obtaining Additional Information.

### ***Enrollment***

The dependent child under this section may be enrolled at any time, preferably within 60 days of the court order.

In addition:

- If the Subscriber parent who is under court order to provide Coverage does not apply, the other parent or the state Medicaid agency may apply for Coverage for the child.
- A Subscriber parent who has individual Coverage must change from individual Coverage to family Coverage.

NOTE: Rates will increase for family Coverage.

- If the parent, who is under a court or administrative order to provide Coverage for the child, is not already a Subscriber, that parent may enroll (if eligible) when the child is enrolled.
- Neither parent may disenroll the child from an active contract while the court or administrative order is in effect, unless the child becomes covered under another plan.

### **Effective Date of Coverage**

- If BCN receives notice within 60 days of the court or administrative order, Coverage is effective as of the date of the order.
- If BCN receives notice later than 60 days from the date of the order, Coverage is effective on the date BCN receives notice.

## **1.4 Principally Supported Child**

### **Eligibility**

A Principally Supported Child must

- Not be the child of the Subscriber or spouse by birth, legal adoption or legal guardianship
- Be less than 26 years of age
- Be unmarried
- Live full-time in the home with the Subscriber
- Not be eligible for Medicare
- Be dependent on the Subscriber for principal financial support in accordance with Internal Revenue Service standards, and have met these standards for at least 6 full months prior to applying for Coverage.

### **Enrollment**

You may apply for Coverage for a Principally Supported Child after you have been the principal support for 6 months. Coverage will begin 3 months after the application is accepted by BCN.

To apply, you must furnish the following:

- Evidence that the child was reported as a dependent on the Subscriber's most recently filed tax return; **or**
- Evidence and a sworn statement that the dependent qualified for dependent tax status in the current year; **and**
- Proof of eligibility if requested by BCN.

## **Effective Date of Coverage**

Coverage for a Principally Supported Child begins on the first day of the month, 3 months after application and proof of support is received and accepted by BCN. The premium payment must have been received by BCN prior to the effective date of Coverage.

## **1.5 Additional Eligibility Guidelines**

The following guidelines apply to all Members:

- Change of Status: You agree to notify BCN within 60 days of any change in eligibility status of you or any Family Dependents. When a Member is no longer eligible for Coverage, he or she is responsible for payment for any services or benefits.
- We will only pay for Covered Services you receive when you are a BCN Member covered under this Certificate. If you are admitted to a Hospital or Skilled Nursing Facility either when you become a Member or when your BCN Membership ends, we will only pay for Covered Services provided during the time you were a Member.

## **SECTION 2: Other Party Liability**

### **IMPORTANT NOTICE**

BCN does not pay claims or coordinate Benefits for Services that:

- Are not provided or Preauthorized by BCN and a Primary Care Physician
- Are not Covered Services under this Certificate

It is your responsibility to provide complete and accurate information when requested by us in order to administer Section 2. Failure to provide requested information, including information about other coverage may result in a denial of claims.

### **Applicable to Members who participate with a HSA**

You (and your family dependent if you have dependent Coverage) generally cannot have any other health coverage that is not a HDHP. You can have additional insurance that provides benefits only for the following.

- Liabilities incurred under workmen's compensation laws, tort liabilities, or liabilities related to ownership or use of property
- A specific disease or illness
- A fixed amount per day (or other period) of Hospitalization

You can also have coverage (whether provided through insurance or otherwise) for the following items:

- Automobile insurance
- Disability
- Dental care
- Vision care

- Long term care

## **2.1 Non-duplication**

- BCN Coverage provides you with the Benefits for health care services as described in this Certificate.
- BCN Coverage does not duplicate Benefits or pay more for Covered Services than the BCN Approved Amount.
- BCN does not allow “double-dipping” meaning that the Member and/or provider is not eligible to be paid by both BCN and another health plan or another insurance policy.
- This is a coordinated Certificate, meaning Coverage described in this Certificate will be reduced to the extent that the services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for payment under such health plan or policy.

## **2.2 Auto Policy and Workers’ Compensation Claims**

- This Certificate is a coordinated Certificate of Coverage. This means that for medical care needed as the result of an automobile accident, if the Member has a coordinated no-fault insurance policy, then BCN will assume primary liability for Covered Services. The no-fault automobile insurance would be secondary.  
If the Member has coverage through a non-coordinated (sometimes called a “full medical”) no-fault automobile insurance policy, then the automobile insurance will be considered the primary plan. BCN would pay Coverage under this Certificate as the secondary plan.
- If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member’s medical services. BCN would provide for Covered Services under this Certificate as the secondary plan.
- If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. BCN would pay for Covered Services under this Certificate as the secondary plan.
- If the motorcycle insurance does not provide medical coverage or if that medical coverage is exhausted, then BCN will pay for Covered Services under this Certificate as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCN will pay secondary.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers’ compensation law or program will not be paid by BCN.
- If any such services are provided by BCN, BCN has the right to seek reimbursement from the other program, insurer or Member who has received reimbursement.
- Applicable BCN Preauthorization and Coverage requirements (i.e. seeking services from a Participating Provider except in Emergent situations) must always be followed for auto or work-related injuries. Failure to follow applicable Preauthorization and or Coverage requirements may leave you solely responsible for the cost of any services received.

## **2.3 Coordination of Benefits**

### **Definitions**

For purposes of this Section 2.3, "certificate" and "policy" mean a certificate, contract or policy issued by the following in connection with a benefit plan under which health, dental, hospital, medical, surgical or sick care benefits are provided to Members:

- a health or medical care corporation
- a hospital physician corporation
- a health maintenance organization
- a dental care corporation
- an insurance company
- a labor-management trustee plan
- a union welfare plan
- an employer organization plan
- an employer self-insurance plan

"Coordination of Benefits" or "COB" is the system for determining the order in which insurers are responsible for providing benefits when there are two or more insurers for a Member, requiring the Primary Plan to make payment first and allowing the Secondary Plan(s) to reduce their benefits so that the combined benefits of all plans and any Member Liability do not exceed the total Allowed expense.

"Determination of Benefits" means determining the amount that will be paid for Covered Services.

"Primary Plan" means the plan whose benefits for a person's health care coverage must be determined first, without taking into consideration coverage available under another plan.

"Secondary Plan" means a plan that is not the Primary Plan, and which is allowed to reduce benefits to the extent the benefits were paid or payable by the Primary Plan, so that the carrier's combined payment does not exceed 100% of the total allowable amount to which the provider, or you, are entitled.

### **Order of Benefits Determination (which policy will pay first)**

When you have coverage under a policy or certificate that does not contain a coordination of benefits provision, that policy will pay first as the Primary Plan. This means benefits under the other coverage will be determined before the benefits of your BCN Coverage.

After those benefits are determined, your BCN benefits and the benefits of the other plan will be coordinated to provide 100% coverage whenever possible for services covered partly or totally under either plan. In no case will payments be more than the amounts to which providers or you as a Member are entitled, and you may still have a remaining Member Liability after all plans have made payment.

When you have coverage under another policy that does have a coordination of benefits provision, these rules apply:

1. The policy that covers you as a Subscriber (policyholder) will be the Primary Plan. The policy that covers you as a dependent will be the Secondary Plan.
2. If the services are rendered to a Dependent Child who is covered by more than one parent's plan, the order of benefits is as follows:
  - a) The Primary Plan is the plan of the parent whose birthday falls earlier in the year (or the plan that has been in effect the longest if both parents have the same birthday) when:
    - The Parents are married or living together
    - A court decree awards custody to both parents without specifying who has responsibility to provide the child's health care expenses or health insurance coverage
    - A court decree states that both parents are responsible for the child's health care expenses or health insurance coverage

- b) In the case of a Dependent Under a Qualified Medical Child Support Order, the Primary Plan is the plan of the parent decreed by a court to be responsible for the child's health care expenses or health insurance coverage if the child's parents are divorced, separated or not living together.

**NOTE:** Failure to give notice within 30 days of a court decree that requires you to be responsible for a child's health care expenses or health insurance coverage may result in a denial of benefits.

- c) If there is no court decree or the court decree awards something other than joint custody and/or is silent as to health care expenses or health insurance coverage, the order of benefits shall be determined as follows:
        - 1) The plan of the custodial parent
        - 2) The plan of the spouse of the custodial parent
        - 3) The plan of the noncustodial parent
        - 4) The plan of the spouse of the noncustodial parent
3. Except in the case of Dependent Child, if two policies cover a person as a dependent, the policy of the person whose birthday falls earlier in the Calendar Year will be considered primary, i.e., those benefits will be determined first.
4. Except in the case of a Dependent Child, if two policies cover a person as a dependent and the birthdays of the two policyholders are identical, the policy that has been in effect longer will be primary.

**NOTE:** With regard to Paragraphs 3 and 4 above, if either policy is lawfully issued in another state, does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries, and each policy determines its payment of benefits after the other, the policy that does not have the COB procedure based on birthdays will determine who pays first.

5. Active/inactive employee — The Plan that covers a Member as an employee who is neither laid-off nor retired, or as that employee's dependent, determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
6. Longer/shorter length of coverage — if none of the above determines the order of benefits, the plan that has covered an employee, member or Subscriber longer determines benefits before the plan that has covered that person for a shorter time.

NOTE: For someone who has coverage under either or both parents' plan and also has his or her own coverage as a dependent under a spouse's plan, then whichever of the following two plans that has been in place longer would be Primary:

- a) The parent's plan which would be primary based on the criteria shown above in #2
- b) The spouse's plan.

In the event coverage under the spouse's plan began on the same date as coverage under the parent's plan, the order of benefits shall be determined using the birthday rule.

### **Continuation Coverage**

If you have group continuation coverage (for example under COBRA or any state or federal law) and coverage under another plan, the plan that covers you as an active employee or as a dependent of an active employee is primary. The plan that provides continuation coverage is secondary.

### **COB Exception**

Benefits under this Certificate will not be reduced or otherwise limited because of a nongroup contract that is issued as a hospital indemnity, surgical indemnity, specified disease or other policy of disability insurance, as defined in section 3400 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.3400 of the Michigan Compiled Laws.

### **COB Administration**

If it is determined that benefits under this certificate should have been reduced because of benefits available under another certificate or policy, BCN has the right to recover from you any payments made to you or recover from the provider who received the payment.

If benefits that should have been paid by BCN have been provided under another certificate or policy, BCN may directly reimburse the provider of services. The provider will reimburse the other payer.

For COB purposes, BCN may release, claim or obtain any necessary information from any insurance company or other organization. Any Member who claims benefits payment under this Certificate must furnish BCN with any necessary information or authorization to do this.

In general, all terms and conditions of this Certificate, including applicable authorization requirements, apply when BCN is the primary carrier or when BCN is providing secondary coverage. However, BCN may waive authorization requirements when the secondary balance

liability is for other cost sharing that represents less than 50% of the Approved Amount for the service provided.

## **2.4 Subrogation and Reimbursement**

Subrogation is the assertion by BCN of your right, or the rights of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Reimbursement is the right of BCN to make a claim against you, your dependents or representatives if you or they have received funds or other valuable consideration from another party responsible for benefits paid by BCN.

### **Definitions**

The following terms are used in this section and have the following meanings:

“**Claim for Damages**” means a lawsuit or demand against another person or organization for compensation for an injury to a person when the injured party seeks recovery for the medical expenses.

“**Collateral Source Rule**” is a legal doctrine that requires the judge in a personal injury lawsuit to reduce the amount of payment awarded to the plaintiff by the amount of benefits BCN paid on behalf of the injured person.

“**Common Fund Doctrine**” is a legal doctrine that requires BCN to reduce the amount received through subrogation by a pro rata share of the plaintiff’s court costs and attorney fees.

“**First Priority Security Interest**” means the right to be paid before any other person from any money or other valuable consideration recovered by:

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

“**Lien**” means a first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCN paid as a result of the plaintiff’s injuries.

“**Made Whole Doctrine**” is a legal doctrine that requires a plaintiff in a lawsuit be fully compensated for his or her damages before any Subrogation Liens may be paid.

“**Other Equitable Distribution Principles**” means any legal or equitable doctrines, rules, laws or statutes that may reduce or eliminate all or part of BCN’s claim of Subrogation.

“**Plaintiff**” means a person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or representative of the injured party.

## **Your Responsibilities**

In certain cases, BCN may have paid for health care services for you or other Members on your Contract that should have been paid by another person, insurance company or organization. In these cases:

- You assign to us your right to recover what BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a Lien or Right of Recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.
- You agree to inform BCN when your medical expenses should have been paid by another party but was not due to some act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your attorney of BCN's rights and your obligations under this Certificate.
- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining written consent from BCN if the settlement relates to services paid by BCN.
- You agree to cooperate with BCN in our efforts to recover money we paid on your behalf.
- You acknowledge and agree that this Certificate supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.
- You acknowledge and agree that this Certificate is a contract between you and BCN and any failure by you, other Members on the Contract or representatives to follow the terms of this Certificate will be a material breach of your contract with us.
  - a) When you accept a BCN ID card for Coverage, you agree that, as a condition to receiving Benefits and services under this Certificate, you will make every effort to recover funds from the liable party.
  - b) When you accept a BCN ID card for Coverage, it is understood that you acknowledge BCN's right of subrogation. If BCN requests, you will authorize this action through a subrogation agreement. If a lawsuit by you or by BCN results in a financial recovery greater than the services and Benefits provided by BCN, BCN has the right to recover its legal fees and costs out of the excess.
  - c) When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and BCN, the costs and legal expenses will be divided equitably.
  - d) You agree not to compromise, settle a claim, or take any action that would prejudice the rights and interests of BCN without obtaining BCN's prior written consent.
  - e) BCN will have the right to recover from you the amount to which BCN has a right to subrogation. If you refuse or do not cooperate with BCN regarding subrogation, it

will be grounds for terminating Membership in BCN upon 30 days written advance notice. You have the right to appeal our decision by contacting Customer Service.

## **SECTION 3: Member Rights and Responsibilities**

### **3.1 Confidentiality of Health Care Records**

Your health care records are kept confidential by BCN, its agents and the providers who treat you.

You agree to permit providers to release information to BCN. This can include medical records and claims information related to services you may receive or have received. BCN agrees to keep this information confidential. Consistent with our Notice of Privacy Practice, information will be used and disclosed only as Preauthorized or as required by or as may be permissible under the law.

It is your responsibility to cooperate with BCN by providing health history information and helping to obtain prior medical records at the request of BCN.

### **3.2 Inspection of Medical Records**

You have access to your own medical records or those of your minor children or wards at your provider's office during regular office hours. In some cases, access to records of a minor without the minor's consent may be limited by law or applicable BCN policy.

### **3.3 Primary Care Physician (PCP)**

BCN requires you to choose a Primary Care Physician. You have the right to designate any Primary Care Physician who is a Participating Physician and who is available to accept you. If you do not choose a Primary Care Physician upon enrollment, we will choose one for you.

For children under the age of 18 ("Minors"), you may designate a Participating pediatrician as the Primary Care Physician if the Participating pediatrician is available to accept the child as a patient. Alternatively, the parent or guardian of a Minor may select a Participating family practitioner or general practitioner as the Minor's Primary Care Physician, and may access a Participating pediatrician for general pediatric services for the Minor (hereinafter "Pediatric Services"). No PCP referral is required for a Minor to receive pediatric services from the Participating pediatrician.

You do not need Preauthorization from BCN or from any other person, including your Primary Care Physician, in order to obtain access to an obstetrical or gynecological care from a Participating Provider who specializes in obstetric and gynecologic care. The Participating specialist, however, may be required to comply with certain BCN procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. The female Member retains the right to receive the obstetrical and/or gynecological services directly from her Primary Care Physician.

Information on how to select a Primary Care Physician, and for a list of Participating Primary Care Physicians, Participating pediatricians and Participating health care professionals

(including certified and registered nurse midwives) who specialize in obstetrics or gynecology is available at [bcbsm.com](http://bcbsm.com) or by calling Customer Service at the number on the back of your BCN ID card.

If after reasonable efforts, you and the Primary Care Physician are unable to establish and maintain a satisfactory physician-patient relationship, you may be transferred to another Primary Care Physician. If a satisfactory physician-patient relationship cannot be established and maintained, you may be asked to disenroll upon 30 days written advance notice; all Dependent Family Members will also be required to disenroll from Coverage. (See Section 5)

### **3.4 Refusal to Accept Treatment**

You have the right to refuse treatment or procedures recommended by Participating Providers for personal or religious reasons. However, your decision could adversely affect the relationship between you and your physician, and the ability of your physician to provide appropriate care for you.

If you refuse the treatment recommended, and the Participating Providers believes that no other medically acceptable treatment is appropriate, the Participating Provider will notify you. If you still refuse the treatment or request procedures or treatment that BCN and/or the Participating Provider regards as medically or professionally inappropriate, treatment of the condition or complications caused by failure to follow the recommendations of the Participating Provider will no longer be payable under this Certificate.

### **3.5 Grievance Procedure**

BCN and your Primary Care Physician are interested in your satisfaction with the services and care you receive as a Member. If you have a problem relating to your care, we encourage you to discuss this with your Primary Care Physician first. Often your Primary Care Physician can correct the problem to your satisfaction. You are always welcome to contact our Customer Service Department with any questions or problems you may have.

We have a formal grievance process if you are unable to resolve your concerns through Customer Service, or to contest an Adverse Benefit Determination.

At any step of the grievance process, you may submit any written materials to help us in our review. You have two years from the date of discovery of a problem to file a grievance with or appeal a decision of BCN. There are no fees or costs charged to you when filing a grievance.

### **Definitions**

**Adverse Benefit Determination** - An Adverse Benefit Determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are

otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

**Pre-service claim** - claims that must be decided before a Member is afforded access to health care.

**Post-service claim** - any claim for a Benefit involving the payment or reimbursement of the cost for medical care that has already been provided.

### ***Review and Decision by the BCN Grievance Panel***

To submit a grievance, you or someone authorized by you in writing, must submit a statement of the problem in writing, to the Appeals and Grievance Unit in the Customer Services department at the address listed below.

Appeals and Grievance Unit – Mail Code C248  
Blue Care Network  
P. O. Box 284  
Southfield, MI 48086-5043  
Fax 888-458-0716

The Appeals and Grievance Unit will review your grievance and give you our decision within 35 calendar days.

The person or persons who made the initial determination are not the same individuals involved in the Grievance Panel. When an adverse determination is made, BCN will provide you with a written statement, in plain English, containing the reasons for the adverse determination, the next step of the grievance process and forms used to request the next grievance step. BCN will provide, upon request and free of charge, all relevant documents and records relied upon in reaching an adverse determination.

If the grievance pertains to a clinical issue, the grievance will be forwarded to an independent Medical Consultant within the same or similar specialty for review. For post-service claims only, if BCN needs to request medical information, an additional 10 business days may be added to the resolution time. When an adverse determination is made, a written statement, in plain English, will be sent within 5-calendar days of the Panel meeting, but not longer than 35-calendar days after receipt of the request for review. Written confirmation will contain the reasons for the adverse determination, the next step of the grievance process and the form used to request an external grievance review. BCN will provide, upon request and free of charge, all relevant documents and records relied upon in reaching an adverse determination.

### ***External Review***

If you do not agree with the decision, you may appeal to the State of Michigan Department of Insurance & Financial Services (DIFS) at [michigan.gov/difs](http://michigan.gov/difs) or at the addresses listed below.

Office of General Counsel – Health Care Appeals Section  
Department of Insurance & Financial Services

(By mail)  
P. O. Box 30220

(By delivery service)  
530 W. Allegan St., 7<sup>th</sup> Floor

Lansing, MI 48909-7720  
Fax: 517-284-8838

Lansing, MI 48933-1521  
1-877-999-6442

When filing a request for an external review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If we fail to provide you with our final determination within 35-calendar days (plus 10 business days if BCN requests additional medical information) from the date we receive your written grievance, you may request an external review from the Director. You must do so within 60 days of the date you received either our final determination or the date our final determination was due. Mail your request for a standard external review, including the required forms that we will provide to you, to the address listed above.

### ***Expedited review***

Under certain circumstances – if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review – you can request an expedited review. You, your doctor or someone acting on your behalf can initiate an expedited review by calling Customer Service or faxing us at 888-458-0716.

We will decide within 72 hours of receiving both your grievance and your physician's confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days.

If you receive an adverse determination, you may request an expedited external review from DIFS within 10-calendar days of receiving our final determination.

## ***3.6 Continuity of Care for Professional Services***

Under Michigan law, when a contract terminates between BCN and a Participating Provider (including your Primary Care Physician) who is treating you for conditions and under the circumstances listed below, the disaffiliated physician may continue treating you.

### ***Continuity of Care for Existing Members***

#### **Physician Requirements**

The Continuity of Care provisions apply only when your physician:

- Notifies BCN of his or her agreement to accept the BCN Approved Amount as payment in full for the services provided
- Continues to meet BCN's quality standards
- Agrees to adhere to BCN medical and quality management policies and procedures

It is the responsibility of the physician to notify you of his or her willingness to continue accepting payment from BCN for Covered Services within 15 days of the date the BCN contract ended.

#### **Medical Conditions and Coverage Time Limits**

If the physician provides notification of such an option, BCN will permit the Member to continue an ongoing course of treatment as follows:

- **Pregnancy Related:** If you are in your second or third trimester of pregnancy at the time of the physician's disaffiliation, services provided by your physician may continue post-partum care for Covered Services directly related to your pregnancy.
- **Terminal Illness:** If you were diagnosed as terminally ill (with a life expectancy of 6 months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the end of the Provider's BCN contract, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.
- **Other Medical Conditions:** For Chronic and Acute medical conditions when a course of treatment began prior to the treating physician's disaffiliation, Coverage for services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first. Your Participating Primary Care Physician must coordinate all other services in order for them to be Covered Services.

### Coverage

If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the "Physician Requirements" listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid, your Participating Primary Care Physician must provide or coordinate all such services.

**NOTE:** You will be responsible for any amount charged by the Non-Participating Provider if the above criteria are not met unless you obtain a referral to the physician from your Primary Care Physician and authorization from BCN.

### ***Continuity of Care for New Members***

If you are a new Member and want to continue an active course of treatment from your existing, Non-Participating Provider, you may request enrollment in BCN's Continuity of Care program. In order for the services to be paid by BCN, at the time of enrollment you must have selected a Primary Care Physician who will coordinate your care with the Non-Participating Provider. Eligibility criteria to participate in the Continuity of Care program include the circumstances and time periods described below:

#### Coverage Time Limits and Qualification Criteria

**Pregnancy Related:** If you are in your second or third trimester of pregnancy at the time of enrollment, coverage provided by your Non-Participating Provider may continue through post-partum care for Covered Services directly related to your pregnancy.

**Terminal Illness:** If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the Non-Participating Provider related to your illness prior to enrollment, Coverage for services provided by your Non-Participating Provider may continue for the ongoing course of treatment through death.

**Other Medical Conditions:** For Chronic and Acute medical conditions when a course of treatment began prior to enrollment, Coverage for services provided by the Non-Participating

Provider may continue through the current period of active treatment or 90 calendar days from the time of enrollment, whichever comes first.

### Coverage

Coverage will be provided for Covered Services for an ongoing course of treatment, subject to Coverage Time Limits and Qualification Criteria detailed above. In order for additional Covered Services to be paid, your Participating Primary Care Physician must provide or coordinate all such services.

**NOTE:** You will be responsible for any amount charged by the Non-Participating Provider if the above criteria are not met unless you obtain a referral to the physician from your Primary Care Physician and authorization from BCN.

### **3.7 Additional Member Responsibilities**

You have the responsibility to:

- Read the Member Handbook, this Certificate and all other materials for Members, and call Customer Service with any questions.
- Comply with the plans and instructions for care that you have agreed on with your practitioners.
- Provide, to the extent possible, complete and accurate information that BCN and its Participating Providers need in order to provide you with care.
- Make and keep appointments for non-emergent medical care. You must call the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Comply with the terms and conditions of the Coverage provided.

### **3.8 Preauthorization Process**

Some services and supplies require Preauthorization by your Primary Care Physician and/or BCN. Section 8 tells you which services and supplies need Preauthorization. You can get a complete and detailed list by contacting customer service. The list may change from time to time.

This chart describes the type of request, Preauthorization procedures and time frames.

Type of Request	Time to Request Additional Information	Time to Obtain Additional Information	Time to Decision	Time to Initial Notification	Time to Written Notification
Pre-service urgent requests requiring additional	Within 24 hours of receipt of request	Within 48 hours of notifying provider of the need for	Within 72 hours from receipt of request	Practitioner notified by telephone or fax within 72 hours from	Written notification is given to Member and provider within 3 days from initial oral notification

information		additional information		receipt of request for approvals or denials	
Pre-service urgent requests with all information	Not applicable	Not applicable	Within 24 hours of receipt of request	Practitioner notified by telephone or fax within 24 hours from receipt of request for approvals or denials	Written notification is given to Member and provider within 3 days from initial oral notification
Pre-service nonurgent requests with all information	Not applicable	Not applicable	Within 14 days from receipt of request	Initial notification is given to Member and provider within 14 days from receipt of request	Written notification is given to Member and provider within 14 days from receipt of request
Pre-service nonurgent requests requiring additional information	Within 5 days of receipt of request - Written request for information is sent to Member and provider	Within a minimum of 45 days of request for information	Within 14 days of receipt of information	Initial notification is given to Member and provider within 14 days from receipt of information	Written notification is given to Member and provider within 14 days from receipt of information
Concurrent care	Within 24 hours of receipt of request	Within 48 hours of notifying provider of the need for additional information	Within 72 hours from receipt of request	Practitioner notified by telephone or fax within 72 hours from receipt of request	Written notification is given to Member and provider within 3 days from initial oral notification
Urgent concurrent care	Not applicable	Not applicable	Within 24 hours of receipt of request	Initial notification is given to provider within 24 hours of receipt of	Written notification of denial is sent to Member and provider within 3 days from initial oral notification

				request	
Post-service requests with all information	Not applicable	Not applicable	Within 30 days of receipt of request	Not applicable	Within 30 days of receipt of request
Post-service requests requiring additional information	Within 5 days of receipt of request. Written request for information is sent to Member and provider	Within a minimum of 45 days of request for information	Within 14 days of receipt of information	Not applicable	Written notification is given to member and provider within 14 days from receipt of information

## **SECTION 4: Forms, Identification Cards, Records and Claims**

### **4.1 Forms and Applications**

You must complete and submit any enrollment form or other forms that BCN requests. You represent that any information you submit is true, correct and complete. The submission of false or misleading information in connection with Coverage is cause for Rescission of your Contract upon 30 days written advance notice. You have the right to appeal our decision to Rescind your Coverage by following the grievance procedure as described in Section 3 and in the Member Handbook. The grievance procedure is also on our website at [bcbsm.com](http://bcbsm.com).

To obtain a copy, you can call Customer Service at the number shown on the back of your BCN ID card.

### **4.2 Identification Card**

You will receive a BCN identification card. You must present this card whenever you receive or seek services from a provider. This card is the property of BCN, and its return may be requested at any time.

To be entitled to Benefits, the person using the card must be the Member on whose behalf all premiums have been paid. If a person is not entitled to receive Benefits, the person must pay for the services received.

If you have not received your card or your card is lost or stolen, please contact Customer Service immediately by calling the number provided in the Member Handbook. Information regarding your BCN ID card is also on our website at [bcbsm.com](http://bcbsm.com).

### **4.3 Misuse of Identification Card**

BCN may confiscate your identification card and may terminate all rights under this Certificate if you misuse your identification card by doing any of the following:

- Repeatedly fail to present the card when receiving services from a provider

- Permit any other person to use the card
- Attempt to or defraud BCN or a provider

#### **4.4 Membership Records**

- We maintain membership records.
- Benefits under this Certificate will not be available unless information is submitted in a satisfactory format by the Member.
- If you or someone applying for Coverage on your behalf misrepresents your tobacco use or state or county of residence, BCN has the right to recover from you the difference in premium between what you are paying and what you should have paid.
- You are responsible for correcting any inaccurate information provided to BCN. If you intentionally fail to correct inaccurate information, you will be responsible to reimburse BCN for any service paid based on the incorrect information.

#### **4.5 Authorization to Receive Information**

By accepting Coverage under this Certificate, you agree that:

- BCN may obtain any information from providers in connection with Services provided to a Member;
- BCN may disclose any of your medical information to your Primary Care Physician; other treating physicians or as otherwise permitted by law; and
- BCN may copy records related to your care.

#### **4.6 Member Reimbursement**

Your Coverage is designed to avoid the requirement that you pay a provider for Covered Services except for applicable Copayments, Coinsurance or Deductible. If, however, circumstances require you to pay a provider, ask us in writing to be reimbursed for those services. Written proof of payment must show exactly what services were received including diagnosis, CPT codes, date and place of service. A billing statement that shows only the amount due is not sufficient.

Additional information on how to submit a claim and the Reimbursement Form is available at [bcbsm.com](http://bcbsm.com) and in the Member Handbook.

Send your itemized medical bills promptly to us.

BCN Customer Service  
P. O. Box 68767  
Grand Rapids, MI 49516-8767

**NOTE: Written proof of payment must be submitted within 12 months of the date of service. Claims submitted 12 months after the date of service will not be reimbursed.**

## **SECTION 5: Termination of Coverage**

### **5.1 Termination of Coverage**

This Certificate is guaranteed renewable and will continue in effect for one year from the effective date and from year to year thereafter, unless terminated as follows:

- This Certificate may be terminated by Blue Care Network with 30 days prior written notice, which shall include reason for termination. Benefits will terminate for Subscriber and Dependents as of the date of termination of this Certificate; and
- If the Subscriber terminates this Certificate, all rights to benefits shall cease as of the effective date of termination.

You must notify us if you want to terminate your Coverage under this Certificate. Once you provide us with this notice, your Coverage will end on one of the following dates:

**NOTE:** If you purchased Coverage under this Certificate on the Marketplace, you may terminate it if you provide us or the Marketplace with proper notice.

- If you notify us at least 14 days before the date you want your Coverage to end, your Coverage will end on your requested date: or
- If you notify us in less than 14 days before the date you want your Coverage to end, we will end it on your requested date only if it is feasible for us to do so; or
- In all other cases, we will end your Coverage 14 days after your request that your Coverage be terminated.

### **5.2 Termination for Nonpayment**

#### **Nonpayment of Premium**

- If you fail to pay the premium by the due date, Coverage for you and your dependents will be terminated.
- If the Coverage is terminated, any Benefits incurred by a Member and paid by BCN after the termination will be charged to the Subscriber as permitted by law.
- Grace Period: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
- If you are receiving an advance payment of a federal premium tax credit and had paid at least one full month of premium during the current benefit year, you will be given a three-consecutive month grace period before we will cancel your Coverage for not paying your premium when due. If you need health care services at anytime during the second and third months of the grace period, we will hold payment for claims beginning on the first day of the second month of the grace period and notify the Participating Provider that we are not paying these claims during this time. If we do not receive your payment in full for all premiums due before the grace period ends, your Coverage will be cancelled. Your last day of Coverage will be the last day of the first month of the three-month grace period. All claims for any health services that were provided after the last day of Coverage will be denied.

## **Nonpayment History**

BCN may refuse to accept an application for enrollment or may decline renewal of any Member's Coverage if the applicant or any Member on the contract has a history of delinquent payment of their share of the costs for Covered Services.

### **Nonpayment of Member's Cost Sharing**

BCN may terminate Coverage for a Member under the following conditions:

- If you fail to pay applicable Copayments, Deductible, Coinsurance or other fees within 90 days of their due date; or
- If you do not make and comply with acceptable payment arrangements with the Participating provider to correct the situation.

The termination will be effective at the renewal date of the Certificate. BCN will give reasonable notice as required by law of such termination.

## **5.3 Termination of a Member's Coverage**

a) Termination\*: Coverage for any Member may also be terminated for any of the reasons listed below. Such termination is subject to legally required notice and grievance rights, if applicable:

- You no longer meet eligibility requirements
- Coverage is cancelled for nonpayment
- You do not cooperate with BCN in pursuing subrogation
- You are unable to establish a satisfactory physician-patient relationship
- You act in an abusive or threatening manner toward BCN or Participating Providers or their staff, other patients
- Misuse of the BCN ID Card that is not fraud or intentional misrepresentation of a material fact
- Misuse of the BCN system that is not fraud or intentional misrepresentation of a material fact
- BCN exits the individual market
- Your cessation of association membership

\*The termination reasons defined above are applicable only if you purchased your Coverage off of the Health Insurance Marketplace. If you purchased your Coverage on the Health Insurance Marketplace, see Section 7.18.

b) Rescission: If you commit fraud that in any way affects your Coverage or make an intentional misrepresentation of material fact to obtain, maintain or that otherwise affects your Coverage, BCN will consider you in breach of contract and, upon 30 days written advance notice your Membership may be Rescinded. In some circumstances, fraud or intention misrepresentation of material fact may include:

- Misuse of the BCN ID card (Section 4)

- Intentional misuse of the BCN system
- Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCN grievance procedure in Section 3 of this Certificate. You can also find this procedure in your Member Handbook, at bcbsm.com or you can contact Customer Service who will provide you with a copy.

## **5.4 Extension of Benefits**

All rights to BCN Benefits end on the termination date **except**:

- Benefits will be extended for a Preauthorized Inpatient admission that began prior to the termination date. Coverage is limited to Facility charges; professional claims are not payable after the termination date.

As noted in Section 1, Benefits are only provided when Members are eligible and covered under this Certificate. However, as permitted by law, this extension of Benefits will continue only for the condition being treated on the termination date, and only until any one of the following occurs:

- You are discharged
- Your Benefit exhausted prior to the end of the contract
- You become eligible for other Coverage

**NOTE:** If Coverage is Rescinded due to fraud or intentional misrepresentation of a material fact, this exception does not apply.

## **SECTION 6: Continuation Coverage**

### **6.1 Loss of Coverage by Dependent**

If a Family Dependent ceases to be eligible for Coverage because of:

- Death of the Subscriber
- Divorce of the Subscriber
- Change of residence
- Loss of dependent status

the Family Dependent may apply for Coverage. A minor or totally disabled dependent who is 19 years or older, may be covered only as a dependent on a parent's contract.

## **SECTION 7: Additional Provisions**

### **7.1 Notice**

Any notice that BCN is required to give its Members will be:

- In writing

- Delivered personally or sent by U.S. Mail
- Addressed to your last address provided to BCN

## **7.2 Change of Address**

You must notify BCN immediately if your address changes. Except as otherwise stated in this Certificate, you must live within the BCN Service Area for at least 180 days a year.

## **7.3 Headings**

The titles and headings in this Certificate are not intended as part of this Certificate. They are intended to make your Certificate easier to read and understand.

## **7.4 Governing Law**

The Certificate of Coverage is made and will be interpreted under the laws of the State of Michigan and federal law where applicable.

## **7.5 Execution of Contract of Coverage**

When you sign the BCN Enrollment Form, you indicate your agreement to all terms, conditions, and provisions of Coverage as described in this Certificate.

## **7.6 Assignment**

The Covered Services provided under this Certificate are for your personal benefit. They cannot be transferred or assigned to another person.

If you try to assign Coverage to another person, all rights will be automatically terminated. BCN will pay providers only in accordance with the provisions of this Certificate.

## **7.7 Policies and Member Handbook**

Reasonable policies, procedures, rules and interpretation may be adopted in order to administer the Certificate. Your Benefits include additional programs and services, as set forth in the Member Handbook.

## **7.8 Litigation**

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written Proof of Loss has been furnished as required by this Certificate. No such action shall be brought after the expiration of 3 years after the time written Proof of Loss is required to be furnished.

You may not file a legal action unless you have first followed the BCN internal grievance process.

## **7.9 Your Contract**

Your contract consists of the following:

- Certificate of Coverage
- Any attached Riders

- Your Member Handbook
- The application signed by the Subscriber
- The BCN identification card

Your Coverage is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us. BCN does not:

- Adjust premiums based on genetic information
- Request/require genetic testing
- Collect genetic information from an individual at any time for underwriting purposes

These documents supersede all other agreements between BCN and Members as of the effective date of the documents.

### **7.10 Reliance on Verbal Communication and Waiver by Agents**

Verbal verification of your eligibility for Coverage or availability of Benefits is not a guarantee of claims payment. All claims are subject to a review of the diagnosis reported, verification of Medical Necessity, the availability of Benefits at the time the claim is processed, as well as the conditions, limitations, exclusions, maximums, Copayments, Deductible and Coinsurance under your Certificate and attached Riders.

No agent or any other person, except an officer of BCN, has the authority to do any of the following:

- Waive any conditions or restrictions of this Certificate
- Extend the time for making payment

No agent or any other person except an officer of BCN has the authority to bind BCN by making promises or representations, or by giving or receiving information.

### **7.11 Amendments**

- This Certificate and the contract between you and BCN are subject to amendment, modification or termination.
- Such changes must be made in accordance with the terms of the Certificate or by mutual agreement between you and BCN with regulatory approval and with prior notice.

### **7.12 Major Disasters**

In the event of major disaster, epidemic or other circumstances beyond the control of BCN, BCN will attempt to provide Covered Services insofar as it is practical, according to BCN's best judgment and within any limitations of facilities and personnel that exist.

If facilities and personnel are not available, causing delay or lack of services, there is no liability or obligation to perform Covered Services under such circumstances.

Such circumstances include, but are not limited to

- Complete or partial disruption of facilities

- Disability of a significant part of facility, BCN personnel
- War
- Riot
- Civil insurrection
- Labor disputes not within the control of BCN

### **7.13 Obtaining Additional Information**

The following information is available to you at [bcbsm.com](http://bcbsm.com) or by writing BCN Customer Service at P.O. Box 68767, Grand Rapids, MI 49516-8767. You can call our Customer Service Department at the number shown on the back of your BCN ID card.

- The current provider network in your Service Area
- The professional credentials of the health care providers who are Participating Providers
- The names of Participating Hospitals where individual Participating Physicians have privileges for treatment
- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider
- Information about the financial relationships between BCN and a Participating Provider
- Preauthorization requirements and any limitations, restrictions or exclusions on Services, Benefits or Providers

NOTE: Some of this information is found in the Member Handbook and [bcbsm.com](http://bcbsm.com).

### **7.14 Right to Interpret Contract**

During claims processing and internal grievances, BCN reserves the right to interpret and administer the terms of the Certificate and any Riders that amend this Certificate. The adverse decisions regarding claims processing and grievances are subject to your right to appeal.

### **7.15 Independent Contactors**

BCN does not directly provide any health care services under this Certificate, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by health professionals in consultation with you. Participating Providers and any other health professions providing health care services to under this Certificate do so as independent contractors.

### **7.16 Clerical Errors**

Clerical errors, such as an incorrect transcription of effective dates, termination dates, or mailings with incorrect information will not change the rights or obligations of you and BCN under this Certificate. These errors will not operate to grant additional benefits, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

## **7.17 Waiver**

In the event that you or BCN waive any provision of this Certificate, you or BCN will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Certificate does not act as a waiver of that right.

## **7.18 Information About Your Bill and Termination of Coverage**

Each bill for a regular billing cycle covers a one-month period.

**If you purchased this coverage on the Health Insurance Marketplace (“Marketplace”) and are eligible for a premium tax credit (subsidy):**

- The Marketplace will determine if you are eligible for a subsidy;
- You are responsible only for your portion of the premium, not the subsidy; and
- You will receive subsidies only if this coverage is available on the Marketplace and you purchase this coverage from the Marketplace.

If you are receiving an advance payment of a federal premium tax credit and had paid at least one full month of premium during the current year, you will be given a three-consecutive month grace period before we will cancel your coverage for not paying your premium when due. If you have health care services at anytime during the second and third months of the grace period we will hold payment for claims for these services beginning on the first day of the second month of the grace period. We will notify your providers that we are not paying these claims during this time.

If we do not receive your payment in full for all premiums due before the grace period ends, your coverage will be cancelled. Your last day of coverage will be the last day of the first month of the three-month grace period. All claims for any health services that were provided after that last day of coverage will be denied.

**If you purchased this coverage either off the Marketplace or on the Marketplace but are not eligible for a subsidy:**

- Subsidies are not available for coverage purchased off the Marketplace;
- You are responsible for the entire premium amount; and
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
- The 90-day grace period does not apply if you do not receive a premium tax credit. If we do not receive your premium by the due date, we will allow you a grace period of 30 days, during which we will send you a final bill. Your coverage will not continue during the grace period. If we receive your premium payment during the grace period, your coverage will be reinstated without a lapse. If we do not receive your payment during the grace period, your coverage will be terminated as of the last day of paid coverage.

NOTE: Premium payments will only be accepted from the Subscriber, Member, blood relative, legal guardian or other person or entity authorized under the law to pay the premium on the Subscriber's behalf.

If you purchased this coverage on the Health Insurance Marketplace (“Marketplace”), BCN will terminate your coverage only:

- If you are no longer eligible for coverage through the Marketplace
- Non-payment of premium (after grace period)
- For Recession for a non-prohibited reason
- If the qualified health plan is terminated or decertified
- You change products
- BCN exits the individual market
- Your cessation of association membership

See Sections 5.1, 5.2 and 5.3b for additional coverage termination information.

### **7.19 Payment of Claim**

Indemnity for loss of life will be payable in accordance with the beneficiary designation.

### **7.20 Reinstatement**

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if BCN or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by BCN or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless BCN has previously notified the Member in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Member and BCN shall have the same rights there under as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

### **7.21 Time of Payment of Claims**

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

### **7.22 Proofs of Loss**

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the

time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

## CHAPTER 2 – YOUR BENEFITS

### **IMPORTANT INFORMATION**

- The Services listed in this chapter are covered when services are provided in accordance with Certificate requirements (including Referral from PCP or other Participating Provider) and, when required, are Preauthorized or approved by BCN except in an Emergency.
- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to
  - Review of the diagnosis reported
  - Verification of Medical Necessity
  - Availability of Benefits at the time the claim is processed
  - Conditions, limitations, exclusions, maximums
  - Coinsurance, Copayments and Deductible under your Certificate and Riders
- If you receive services that we do not cover, you will pay for the services.
- Your PCP or other Participating Provider must coordinate Referrals and Preauthorizations. You cannot self-refer unless specified in this Certificate.
- Medical Services defined in this Certificate provided in accordance with the terms of this Certificate are Covered Services only when they are Medically Necessary.
- If you purchase a deluxe item or equipment when not Medically Necessary, the Approved Amount for the basic item applies toward the price of the deluxe item. You are responsible for any costs over the Approved Amount.
- Coverage is subject to the limitations and exclusions listed in this Chapter.
- A Rider may be attached to this Certificate. It applies or revises Copayments, Coinsurance, Deductible, Out-of-Pocket Maximum and/or Benefit Maximums.
- When a Rider is attached to this Certificate, the Rider will take precedence.
- You have other Benefits and Services like
  - Disease management
  - Prevention
  - Wellness
  - Care management services.

You can find more details in the Member Handbook and on [bcbsm.com](http://bcbsm.com).

- For an updated list of Services that require Preauthorization, contact Customer Service at the number shown on the back of your BCN ID card.

## SECTION 8: Your Benefits

### 8.1 Cost Sharing

Cost Sharing may be applied to this Certificate and is detailed in the Riders attached to this Certificate.

#### **Deductible**

The Deductible is the fixed amount you are responsible to pay each year before BCN will pay for Covered Services. Your Deductible is based on amounts defined annually by the federal government for High Deductible Health Plans. Changes in the federal government amounts will affect your Deductible.

BCN begins paying for Covered medical services and prescription drugs only after the total amount of the Deductible has been met with the exception of Preventive Services. The Deductible does not apply to Preventive Services (Section 8).

#### Aggregate Deductible

If there are two or more Members on a family Contract, the entire family Deductible amount (Aggregate Deductible) must be met before BCN pays for any expenses for any one person covered under the Plan. **Aggregate Deductible** means there is one family Deductible amount that must be met first. The entire family Deductible may be satisfied by one family member or the combined (aggregate) of the entire family. The Deductible does accumulate towards the Out-of-Pocket Maximum.

The Approved Amount will be applied to the Deductible for medical and pharmacy Covered Services. Charges paid by a Member in excess of the Approved Amount or for non-covered services do not apply toward the Deductible.

Your Deductible renews each Calendar Year. It does not carry over to the new year.

NOTE: Your Deductible amount may be amended by a Rider attached to this Certificate.

#### **Copayment**

You have no Copayments under this Certificate *unless* a Rider is issued to you that amends your Coverage and applies a Copayment to specific services. Copayments do count toward your Out-of-Pocket Maximum. Once you meet your Out-of-Pocket Maximum, you will not be responsible for Copayments for the remainder of the Calendar Year.

#### **Coinsurance**

You pay no Coinsurance for Covered Services with the exception of the following services. Your Coinsurance is 50% of the Approved Amount after the Deductible is satisfied for the Services listed below.

- Infertility counseling and treatment
- Male sterilization
- Durable medical equipment
- Prosthetics and orthotics
- TMJ treatment
- Weight reduction procedures

NOTE: A Rider may be issued to you that amends this Certificate and applies a Coinsurance to services with 100% Coverage. The Coinsurance will not apply to Preventive Services (Section 8).

### **Cost Sharing – Deductible, Coinsurance and Copayment Calculation**

If you have a Coinsurance or Copayment for a particular Service as well as a Deductible, you will first be responsible for the payment of the Deductible. The Coinsurance or Copayment will be based on the remaining balance of the Approved Amount. BCN will be responsible to make payment to the provider only after the Deductible, Coinsurance, and Copayment have been paid.

### **Out-of-Pocket Maximum**

The Out-of-Pocket Maximum is the most you will pay for Covered Services under this Certificate and any attached Riders per Calendar Year. The Out-of-Pocket Maximum includes your medical and BCN Prescription Drug Deductible, Copayment and Coinsurance.

The maximum amount is set annually by the federal government.

Once you reach the Out-of-Pocket Maximum, you will not pay Deductible, Copayments or Coinsurance for Covered Services for the remainder of the Calendar Year with the following exceptions:

- Any Premium or contributions paid toward the Premium do not apply to the Out-of-Pocket Maximum
- Charges paid by you in excess of the Approved Amount do not apply toward the Out-of-Pocket Maximum
- Services that are not a Benefit under this Certificate do not apply to the Out-of-Pocket Maximum

Your Out-of-Pocket Maximum renews each Calendar Year. It does not carry over to the new year.

NOTE: Out-of-Pocket Maximum amount may be amended by a Rider attached to this Certificate.

### **Benefit Maximum**

Some of the Covered Services described in the Certificate are covered for a limited number of days or visits per Calendar Year. This is known as the Benefit Maximum. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of the additional services received during that Calendar Year even when continued care may be Medically Necessary.

Some Covered Services have a Benefit Maximum. They include but are not limited to

- Medical rehabilitation
- Spinal manipulation
- Skilled nursing care

## **8.2 Professional Physician Services (Other Than Mental Health and Substance Abuse)**

### **We cover**

#### **A) Office Visits** at an office site or hospital location provided by:

- Primary Care Physician
- BCN Participating OB/GYN for female Members
- Referral Physician

Covered in full after Deductible

NOTE: Non-preventive diagnostic, therapeutic and surgical procedures performed in the office are subject to the applicable Deductible. See Preventive and Early Detection Services and Outpatient Services sections for further information about office visits.

#### **B) Maternity prenatal and postnatal office visits** when provided by your Primary Care Physician or Participating OB/GYN. Maternity education is covered when provided by your PCP or Participating OB/GYN.

*Routine prenatal maternity care* is covered in full; Deductible does not apply

*Non-routine maternity care* is covered in full after Deductible

NOTE: If Cost Sharing Rider is attached, Cost Sharing does not apply to routine prenatal visits. The Cost Sharing does apply to non-routine (non-preventive) high risk prenatal visits.

#### **C) Home Visits** by a physician in your home or temporary residence. For Home Health Care Services other than physician visits, see the Home Health Care Services section in this chapter for additional information.

Covered in full after Deductible

#### **D) Inpatient Professional Services** while you are in an Inpatient Hospital or Skilled Nursing Facility or Inpatient rehabilitation center and billed by a physician when Preauthorized by BCN.

Covered in full after Deductible

- E) Allergy Care** — Allergy testing, evaluation, serum, injection of allergy serum and related office visits

Covered in full after Deductible

- F) Chiropractic Services and Osteopathic Manipulative Therapy** when provided by a BCN Participating Chiropractor or Osteopathic Physician, referred by your Primary Care Physician and Preauthorized by BCN

### **Coverage**

Covered in full after Deductible

Office visits are covered the same as Referral Physician office visits as defined above. When an office visit and spinal manipulation are billed on the same day by the same provider, only one Copayment will be required for the office visit.

Mechanical traction once per day is covered when it is performed with chiropractic spinal manipulation.

Radiological services and X-rays are covered when Preauthorized.

See Outpatient Services section and any attached Riders for Cost Sharing information.

### **Benefit Maximum**

Osteopathic manipulative therapies on any location of the body and chiropractic spinal manipulations to treat misaligned or displaced vertebrae of the spine are limited to the Benefit Maximum of 30 combined visits per Member per Calendar Year. For example, a spinal manipulation performed by a Chiropractor will reduce the number of spinal manipulations available from an Osteopathic Physician.

Visits for mechanical traction are applied toward your Benefit Maximum for physical, speech and language pathology, and occupational therapy services. Any combination of therapies (mechanical traction or physical, speech and language pathology, and occupational therapy) is limited to a combined Benefit defined under Outpatient Therapy section.

- G) Eye Care** — Treatment of medical conditions and diseases of the eye when services are referred by your Primary Care Physician and Preauthorized by BCN

Covered in full after Deductible

## **8.3 Preventive and Early Detection Services**

We cover Preventive and Early Detection Services as defined in the federal Patient Protection and Affordable Care Act. These services must be provided or coordinated by your Primary Care Physician. Services are modified by the federal government from time to time.

Preventive Services include but are not limited to the following:

- **Health screenings, health assessments, and adult physical examinations** set at intervals in relation to your age, sex and medical history.

**Health screenings** include but are not limited to:

- Obesity
  - Glaucoma
  - EKG
  - Vision and hearing (See Section 9 for exclusions)
  - Type 2 diabetes mellitus
  - Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)
- **Women’s health and well being**
    - Gynecological (well woman) examinations including routine pap smear and mammography screening
    - Screening for sexually transmitted diseases; HIV counseling and screening
    - Contraceptive counseling and methods; office administered contraceptive devices and appliances; such as intrauterine devices (IUDs); implantable and injected drugs such as DepoProvera; and diaphragms including measurement, fittings, removal, administration and management of side effects
    - Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling
    - Routine preventive prenatal office visits
    - Breast pump and associated supplies needed to support breast feeding covered only when Preauthorized and purchased from a Participating Durable Medical Equipment provider. Breast pumps are limited to no more frequent than one every 24 months. Convenience items such as storage containers, bags, bottles and nipples are not covered. (See Durable Medical Equipment section for limitations and exclusions);
    - Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening
    - Screening for gestational diabetes
    - Bone density screening
    - Screening and counseling for interpersonal and domestic violence;
    - Female sterilization services
    - Genetic counseling and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes
  - **Newborn and well-child assessments and examinations**
  - **Immunizations** (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN

- Screening colonoscopy and flexible sigmoidoscopy
- **Morbid Obesity Weight Management** - Dietician services billed by a physician or other provider recognized by BCN
- Depression screening, substance abuse/chemical dependency when performed by the Primary Care Physician
- **Nutritional counseling** including Diabetes Self-Management, morbid obesity, and diet behavioral counseling. Other nutritional counseling services may be covered when Preauthorized by your Primary Care Physician and BCN.

NOTE: Certain health education and health counseling services may be arranged through your Primary Care Provider, but are not payable under your Certificate.

Examples include but are not limited to:

- Lactation classes not provided by your physician
  - Tobacco cessation programs (other than a BCN tobacco cessation program)
  - Exercise classes
- **Aspirin therapy counseling** for the prevention of cardiovascular disease
  - Tobacco use and tobacco caused disease counseling

NOTE: Deductible (Cost Sharing) will apply to non-routine diagnostic procedures.

NOTE: If this Certificate is amended by Deductible, Copayment and/or Coinsurance Riders, the attached Riders will take precedence over the Certificate for non-preventive services. Deductibles, Copayments and/or Coinsurance (“Cost Sharing”) will apply to non-routine diagnostic procedures only. Any Member Cost Sharing for office visits will still apply with the following restrictions:

- If a recommended Preventive Service or Early Detection Service is billed separately from the office visit, then you will be responsible for the office visit Cost Sharing, but there will be no Cost Sharing for the Preventive Service;
- If a recommended Preventive Service or Early Detection Service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of the Preventive Service, you will have no Cost Sharing for the office visit; and
- If a recommended Preventive Service or Early Detection Service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of the Preventive Service, you will be responsible for payment of any Cost Sharing for the office visit.

NOTE: To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org). You may also contact BCN Customer Service.

## **8.4 Inpatient Hospital Services**

We cover the following Inpatient Hospital (Facility) and Professional Services in full after Deductible. Inpatient Hospital Services include but are not limited to the list below when they are Medically Necessary and Preauthorized by BCN.

- Room and board, general nursing services, special diets
- Operating and other surgical treatment rooms, delivery room, and special care units
- Anesthesia, laboratory, radiology, and pathology services
- Chemotherapy, inhalation therapy and dialysis
- Physical, speech, and occupational therapy
- Long-term Acute Care
- Other Inpatient Services and supplies necessary for the treatment of the Member
- Maternity care and routine nursery care of a newborn

NOTE: The mother and newborn child are covered for no less than the following length of stay in a Hospital in connection with childbirth except as excluded under Section 9:

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

Hospital length of stay begins at the time of delivery if delivery occurs in a Hospital and at time of admission in connection with childbirth if delivery occurs outside the Hospital. BCN Prior Authorization is not required for the minimum Hospital stay.

Certain other Inpatient Hospital Services may have separate requirements. Your Cost Sharing is different. (See, for example, Coverage for infertility; treatment of TMJ, weight reduction procedures and any attached Riders.)

See Inpatient Professional Services section.

## **8.5 Outpatient Services**

We cover Outpatient Services in full after Deductible when Medically Necessary and Preauthorized by your treating physician and BCN.

You receive Outpatient Services in these settings

- Outpatient Hospital
- Physician office
- Free standing ambulatory center
- Dialysis center

Outpatient Services include but are not limited to

- Surgical treatment
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, inhalation therapy, radiation therapy and dialysis

- Physical, speech and occupational therapy - see Outpatient Therapy Services
- Injections (for allergy) - see Professional Physician Services (Other Than Mental Health and Substance Abuse)
- Professional Services - see Professional Physician Services (Other Than Mental Health and Substance Abuse)
- Durable medical equipment and supplies - see Durable Medical Equipment
- Diabetic supplies and equipment - see Diabetic Supplies and Equipment
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics
- Other Medically Necessary Outpatient Services and supplies

Preventive lab and radiology Services are covered in full; Deductible does not apply

Certain Outpatient Services have separate requirements. Your Cost Sharing is also different. (See, for example, Coverage for infertility; treatment of TMJ, and weight reduction procedures and any attached Riders.)

## **8.6 Emergency and Urgent Care**

### **Definitions**

**Accidental Injury** – a traumatic injury, which if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.

**Emergency Services** – services to treat a Medical Emergency as described above

**Medical Emergency** – the sudden onset of a serious medical condition resulting from injury, sickness or mental illness that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily function, or serious dysfunction of any bodily organ or part

**Stabilization** – the point at which it is reasonably probably that no material deterioration of a condition is likely, within reasonable probability, to result from or occur during your transfer

**Urgent Care Services** – services that appear to be required in order to prevent serious deterioration to your health resulting from an unexpected sudden illness or injury that could be expected to seriously worsen if not treated within 24 hours. Examples include: flu, strep throat, or other infections; foreign material in the eye, sprain or pain following a fall; and a cut, sore or burn that does not heal.

### **Coverage**

Emergency Services and Urgent Care Services are covered after Deductible up to the point of Stabilization when they are Medically Necessary and needed either 1) for immediate treatment of a condition that is a Medical Emergency as described above, or 2) if the Primary Care Physician directs you to go to an emergency care Facility.

In case of such Medical Emergency or Accidental Injury, you should seek treatment at once. We urge you, the Hospital or someone acting for you to notify your Primary Care Physician or BCN within 24 hours, or as soon as medically reasonable. Inpatient emergent admissions require Preauthorization by BCN.

Emergency Services include professional and related ancillary services and Emergency Services provided in an urgent care center or Hospital emergency room.

Emergency Services are no longer payable as Emergency Services at the point of the Member's Stabilization as defined above.

**NOTE:** Observation stay resulting from Emergency Services is subject to emergency room Cost Sharing if an Emergency Room Rider is added to your Coverage.

**Follow-up care** in an emergency room or Urgent Care Facility - such as removal of stitches and dressings - is a Covered Benefit only when Preauthorized by your Primary Care Physician and by BCN. This applies even if the Hospital emergency staff or physician instructed you to return for follow up.

### ***Admission to a Non-Participating Hospital after Emergency Services***

If you are hospitalized in a Non-Participating Hospital, we may require that you be transferred to a Participating Hospital as soon as you have Stabilized. If you refuse to be transferred, all related non-Emergency Covered Services will not be covered from the date of Stabilization.

### ***Payment for Emergency Care***

We will pay the BCN Approved Amount. Our Approved Amount is the greater of the median in-network rate; the usual, customary and reasonable rate, or the Medicare rate. You are responsible for any Cost Sharing required under your Rider.

We will pay the greater of the median In-network rate; the usual, customary and reasonable rate; or the Medicare rate. You are responsible for any Cost Sharing required under your Rider.

## ***8.7 Ambulance***

An ambulance is a vehicle specially equipped and licensed for transporting injured or sick persons.

**We cover ambulance Services in full after Deductible.**

- **Air Ambulance** for emergency transport to the nearest Hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and must be verified by the records of the physician who treats you and by the ambulance company. An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.

- **Emergency ground ambulance services** when
  - You are admitted to the Hospital immediately following emergency room treatment
  - The services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management
  - The services are needed for emergency delivery and care of a newborn and mother. (The services are not covered for normal or false labor)
  - The ambulance is ordered by an employer, school, fire or public safety official, and you are not in a position to refuse
- **Non-emergency ground ambulance services** when Preauthorized by your treating physician and BCN

***Exclusions include but are not limited to***

- Transportation and/or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services provided as part of a response to an accident or emergency situation, like accident clean-up or 911 costs are not a covered benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Ambulance services provided by an emergency responder that does not provide on-site treatment and transportation are not covered. The on-site treatment is covered regardless if transportation is provided.

**8.8 Reproductive Care and Family Planning**

This Benefit includes

- Genetic testing
- Voluntary sterilization
- Non-elective Abortion
- Infertility

**A) Genetic Testing**

We cover medically indicated genetic testing and counseling when they are Preauthorized by BCN and provided in accordance with generally accepted medical practice.

NOTE: Genetic counseling and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes is covered with no Cost Sharing. (See Preventive and Early Detection Services section)

Covered in full after Deductible

***Exclusions include but are not limited to***

Genetic testing and counseling for non-Members

## **B) Voluntary Sterilization**

We cover Inpatient, Outpatient, and office based male sterilization services.

Female Sterilization: Covered in full as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services; Deductible does not apply.

### **Cost Sharing**

Male sterilization: 50% Coinsurance of the Approved Amount after Deductible of all fees associated with Facility, professional and related services; Applies toward Out-of-Pocket Maximum

### **Exclusions include, but are not limited to**

Reversal of surgical sterilization for males and females

## **C) Non-Elective Abortion**

We cover a non-elective abortion **only** on the following instances:

- To preserve the life or health of the child after live birth;
- To remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman;
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death; or
- Treatment upon a woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

### **Cost Sharing**

Your inpatient and outpatient benefit applies to non-elective abortion procedures including office consultations as defined in applicable Riders attached to your plan.

### **Exclusions include but are not limited to**

- Any service related to Elective Abortions with the exception of office consultations
- Cases not identified above
- Abortions otherwise prohibited by law

## **D) Infertility**

We cover diagnosis, counseling and planning services for treatment of the underlying cause of infertility when Medically Necessary and Preauthorized by your Primary Care Physician and BCN except as stated below and in Section 9.

Examples of Covered Services

- Sperm count
- Endometrial biopsy
- Hysterosalpingography

- Diagnostic laparoscopy

Following the initial sequence of diagnostic work-up, additional work-ups may begin only when BCN determines they are in accordance with generally accepted medical practice.

### **Cost Sharing**

50% Coinsurance of the BCN Approved Amount after Deductible for all fees associated with infertility diagnostic work-up procedures, treatment and all Facility professional and related services; Applies toward Out-of-Pocket Maximum

### **Exclusions include but are not limited to**

- Harvesting
- Storage or manipulation of eggs and sperm
- Sperm washing
- Post-coital test
- Monitoring of ovarian response to ovulatory stimulants
- Ovarian wedge resection or ovarian drilling
- Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
- Any procedure done to enhance reproductive capacity and fertility
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- Artificial insemination, in-vitro fertilization (IVF) procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related services, and any other assisted reproduction procedure
- Prescription drugs designed to achieve pregnancy
- All services and fees related to surrogate parenting arrangements including, but not limited to, maternity and obstetrical care for non-Member surrogate parents
- Reversal procedures and other infertility services for couples who have undergone a prior voluntary sterilization procedure (e.g. vasectomy or tubal ligation)

## **8.9 Skilled Nursing Facility**

We cover Skilled Nursing Facility services in full after Deductible for recovery from surgery, disease or injury. Skilled Nursing care must be Medically Necessary and Preauthorized by BCN.

### **Benefit Maximum**

Up to a total Benefit Maximum of 45 days per Calendar Year

### **Exclusions include but are not limited to**

- Bed-hold charges incurred when you are on an overnight or weekend pass during an Inpatient stay
- Basic custodial care (See Section 9)

## **8.10 Hospice Care**

Hospice care is an alternative form of medical care for terminally ill Members with a life expectancy of 6 months or less. Hospice care provides comfort and support to Members and their families when a life limiting illness no longer responds to cure oriented treatments.

Hospice care in a Participating licensed hospice Facility, hospital or Skilled Nursing Facility is covered. We also cover hospice care in the home. Hospice care has to be Medically Necessary and Preauthorized by BCN.

### **We cover in full after Deductible**

- Professional visits (such as physician, nursing, social work, home-health aide and physical therapy)
- Durable medical equipment (DME) related to terminal illness
- Medications related to the terminal illness (e.g. pain medication)
- Medical/surgical supplies related to the terminal illness
- Respite care in a Facility setting

NOTE: Short-term Inpatient care in a licensed hospice Facility is covered when Skilled Nursing Services are required and cannot be provided in other settings. Preauthorization is required.

### **Exclusions include but are not limited to**

- Housekeeping services
- Food, food supplements and home delivered meals
- Room and board at an extended care Facility or Hospice Facility for purposes of delivering Custodial Care

## **8.11 Home Health Care Services**

We cover Home Health Care Services for Members who are confined to their home as an alternative to long-term hospital care.

Home HealthCare must be

- Medically Necessary
- Provided by a Participating Home Health Care agency
- Provided by professionals employed by the agency and who participate with the agency

### **We cover in full after the Deductible**

- Skilled nursing care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy  
NOTE: Outpatient therapy limits as defined in Outpatient Therapy Services section do not apply.
- Hospice care
- Other health care services approved by BCN when they are performed in the Member's home

### **Exclusions include but are not limited to**

- Housekeeping services
- Custodial care (See Section 9)

### **8.12 Home Infusion Therapy Services**

Home infusion therapy services provide for the administration of prescription medications and biologics (including antibiotics, total parenteral nutrition, blood components or other similar products) that are administered into a vein or tissue through an intravenous (IV) tube. These services are provided in the Member's home or temporary residence (such as Skilled Nursing Facility).

#### Food Supplements

Supplemental feedings administered *via tube*:

This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy, are covered.

Supplemental feedings administered *via an IV*:

This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

**We cover in full after Deductible**

Home infusion therapy services when Medically Necessary and Preauthorized by BCN

### **8.13 Mental Health Care**

We cover evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions. Non-Emergency Mental Health services must be Preauthorized as Medically Necessary by BCN. (Mental Health Emergency Services are covered pursuant to Emergency and Urgent Care section.)

- Coverage is limited to solution-focused treatment and crisis interventions. Solution-focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic illness or to those Outpatient services that are Medically Necessary in order to prevent an Acute episode of a Chronic illness.
- Medical services required during a period of mental health admission must be Preauthorized separately by your Primary Care Physician and BCN.

## **Definitions**

**Inpatient Mental Health Service** is the service provided during the time you are admitted to a BCN approved acute care Facility that provides continuous 24-hour nursing care for comprehensive treatment.

**Intensive Outpatient Mental Health** services are acute care services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 2 days per week and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan.

**Outpatient Mental Health** services include individual, conjoint, family or group psychotherapy and crisis intervention.

**Partial Hospitalization Mental Health** is a comprehensive acute care program that consists of a minimum of 6 hours per day, 5 days a week. Treatment may include, but is not limited to counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of Inpatient psychiatric Hospitalization.

**Residential Mental Health Treatment** is treatment that takes place in a licensed mental health facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists.

Residential treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that will allow the individual to successfully reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the Member's usual living environment; and
- Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program"), however, the benefit design will be the same as your medical inpatient benefit when Preauthorized by BCN.

## **Coverage**

Mental health care is covered in either an Inpatient or Outpatient setting. To obtain services call Behavioral Health Management at the number shown on the back of your BCN ID card. They are available 24 hours a day, 7 days a week. You do not need a Referral from your Primary Care Physician to get care.

## **Cost Sharing**

### **A) Inpatient Mental Health/Residential Mental Health/Partial Hospitalization**

Covered in full after Deductible

### **B) Outpatient Mental Health/Intensive Outpatient Mental Health**

Covered in full after Deductible

NOTE: Diagnostic testing, injections, therapeutic treatment and medical services are subject to the medical Outpatient Services Cost Sharing.

See Section 9 for Exclusions and Limitations.

## **8.14 Autism Spectrum Disorders**

### **Definitions**

**Applied Behavioral Analysis**, or ABA, means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct-observation, measurement, and functional analysis of the relationship between environment and behavior.

**Approved Autism Evaluation Center (AAEC)** is an academic and/or Hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders. AAEC evaluation is necessary for Applied Behavioral Analysis.

**Autism Spectrum Disorders (ASD)** is defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

**Evaluation** must include a review of the Member's clinical history and examination of the Member. Based on the Member's needs, as determined by the BCN approved Treatment Center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

**Line Therapy** means tutoring or other activities performed one-on-one with person diagnosed with Autism Spectrum Disorder according to a Treatment Plan designed by a BCN Approved Autism Evaluation Center and a Board Certified Behavioral Analyst.

**Preauthorization Process** occurs before treatment is rendered in which a BCN nurse or case manager approves the initial Treatment Plan and continued services. A request for continued services will be authorized contingent on the Member demonstrating measurable improvement and therapeutic progress, which can typically occur at 3, 6, or 9 month intervals after the onset of treatment.

**Treatment Plan** is a detailed, comprehensive, goal-specific plan of recommended therapy for the Autism Spectrum Disorders covered under this Certificate.

### **Benefits**

Services for the diagnosis and treatment of Autism Spectrum Disorders, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified are covered when performed by a BCN approved Participating Provider. Covered diagnostic services must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule. Services for the treatment of Autism Spectrum Disorders are covered as follows:

- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's Autism Spectrum Disorder
- Therapeutic care as recommended in the Treatment Plan include:
  - Occupational therapy, speech and language therapy and physical therapy (when performed by a licensed certified and Participating occupational therapist, speech therapist and physical therapist)
  - Applied Behavior Analysis (when performed by a Participating board-certified behavior analyst and licensed-certified psychologist)
  - Outpatient Mental Health therapy when performed by a licensed certified and Participating social worker, clinical psychologist, and psychiatrist
  - Genetic testing
  - Social skills training
  - Nutritional therapy
- Services and treatment must be Medically Necessary, Preauthorized and deemed safe and effective by BCN
- Services deemed experimental or ineffective by BCN are covered only when mandated by law, included in a Treatment Plan recommended by the BCN Approved Autism Evaluation Center that evaluated and diagnosed the Member's condition and when approved by BCN.

## Coverage

Benefits are available to children through the age of 18 for covered medical-surgical services, Outpatient therapy services and/or behavioral health services including the diagnostic therapeutic services described above. This age limitation does not apply to Outpatient Mental Health services (excluding applied behavioral analyses services) and services used to diagnose Autism Spectrum Disorders.

ABA for Line Therapy Services is subject to the Cost Sharing as defined in the attached Cost Sharing Rider. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Behavioral health services included in the Treatment Plan are subject to the Cost Sharing as defined in the attached Cost Sharing Rider. You are required to pay any Copayment at the time the service is rendered. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Outpatient therapy services included in the Treatment Plan are subject to the Cost Sharing as defined in the attached Cost Sharing Rider. You are required to pay your Copayment at the time the service is rendered. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Services performed pursuant to the recommended Treatment Plan will not count toward Benefit Maximums in your Coverage, including but not limited to, visit or treatment limits imposed on physical therapy, speech-language pathology or occupational therapy.

This Coverage overrides certain exclusions as defined in this Certificate such as exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities and treatment solely to improve cognition concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought when a Member is being treated for covered Autism Spectrum Disorders.

### **Benefit Limitations**

Coverage is available subject to the following requirements:

- **Preauthorization** – Services performed under the recommended Treatment Plan must be approved for payment during BCN’s Preauthorization Process. If Preauthorization is not obtained, rendered services will not be covered and the Member may be held responsible for payment for those services.
- **Prior Notification** – BCN must receive prior notification of the evaluation and diagnostic assessment of the Member
- **Providers** – All services to treat Autism Spectrum Disorders must be performed by a BCN approved provider
- **Required Diagnosis for Applied Behavioral Analysis** – The Member must be evaluated and diagnosed with Autistic Spectrum Disorder by a Participating psychiatrist, development pediatrician or other professional as agreed upon by a BCN Approved Autism Evaluation Center (AAEC) in order to receive authorization for ABA. Other authorization requirements may also apply. The requirement to be evaluated and diagnosed by a BCN Approved Autism Evaluation Center does not exist for other services related to Autism Spectrum Disorder.
- **Termination at age 19** – Benefits are limited to children up to and including the age of 18. This age limitation does not apply to Outpatient Mental Health services (excluding applied behavioral analyses services) and services used to diagnose Autism Spectrum Disorders. Benefits for Autism Spectrum Disorder terminate on the child’s 19th birthday.
- **Treatment Plan** – Applied Behavioral Analysis Services must be included in a Treatment Plan recommended by a BCN Approved Autism Evaluation Center that evaluated and diagnosed the Member’s condition.
  - Measurable improvement in the Member’s condition must be expected from the recommended Treatment Plan. Once treatment begins, the plan will be subject to periodic assessment by BCN nurse or case manager.

### **Exclusions include but are not limited to**

- Any treatment that is not specifically covered herein and that is considered experimental/investigational by, or is otherwise not approved by BCN including, but not limited to, sensory integration therapy and chelation therapy
- Conditions such as Rett’s Disorder and Childhood Disintegrative Disorder

### **8.15 Substance Abuse Services/Chemical Dependency**

Substance Abuse/Chemical Dependency treatment means treatment for physiological or psychological dependence on or abuse of alcohol, drugs or other substances. Diagnosis and

treatment may include drug therapy, counseling, detoxification services, medical testing, diagnostic evaluation, and referral to other services in a Treatment Plan.

Non-emergency Substance Abuse/Chemical Dependency treatments must be Preauthorized as Medically Necessary by BCN. (Substance Abuse/Chemical Dependency Emergency Services are covered pursuant to Emergency and Urgent Care services section.)

- Coverage is limited to solution focused treatment and crisis intervention. Solution-focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic illness or to those Outpatient services that are Medically Necessary in order to prevent an Acute episode of a Chronic illness.
- Medical Inpatient services required during a period of substance abuse admission must be Preauthorized separately by your Primary Care Physician and BCN.

### **Definitions**

**Detoxification** means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detoxification (Detox) can occur in an Inpatient, Outpatient or residential setting.

**Domiciliary Partial** refers to Partial Hospitalization combined with an unsupervised overnight stay (residential) component.

**Intensive Outpatient Substance Abuse Treatment** means day treatment that is provided on an Outpatient basis. Intensive Outpatient services consists of a minimum of 3 hours per day, 2 days per week and might include but is not necessarily limited to individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services specified in a Treatment Plan.

**Intermediate Care** refers to substance abuse services that have a residential (overnight) component. Intermediate Care includes detoxification, domiciliary partial and residential (including “Inpatient” and “rehab”) services.

**Outpatient Substance Abuse Treatment** means Outpatient visits (for example: individual, conjoint, family or group psychotherapy) for a Member who is dependent on and/or abusing alcohol or drugs (or both). The visit may include counseling, detoxification, medical testing, diagnostic evaluation and referral for other services.

**Partial Hospitalization/Domiciliary Partial** is a comprehensive, acute-care program that consists of a minimum of 6 hours per day, 5 days a week. Partial Hospitalization treatment

might include, but is not necessarily limited to counseling, medical testing, diagnostic evaluation and/or referral to other services in a Treatment Plan.

**Residential Substance Abuse Treatment** means Acute services provided in a secure full day (24 hour) setting to a Member who is ambulatory and does not require medical Hospitalization. Residential Services may include counseling, detoxification, medical testing, diagnostic evaluation and referral or other services specified in a Treatment Plan. Residential Substance Abuse Treatment is sometimes also referred to as Inpatient substance abuse treatment or rehabilitation (“rehab”).

### **Coverage**

We cover Substance Abuse Services including counseling, medical testing, diagnostic evaluation and detoxification in a variety of settings. To obtain services call BCN Behavioral Health Management at the number shown on the back of your BCN ID card. They are available 24 hours a day 7 days a week. You do not need a referral from your Primary Care Physician to get care.

### **Cost Sharing**

#### **A) Detoxification/Residential/Intermediate Care/Partial Hospitalization**

Covered in full after Deductible

#### **B) Outpatient/Intensive Outpatient Substance Abuse**

Covered in full after Deductible

NOTE: Diagnostic testing, injections, therapeutic treatment and medical services are subject to the medical Outpatient Services Cost Sharing.

See Section 9 for Exclusions and Limitations.

### **8.16 Outpatient Therapy Services**

Outpatient therapy and/or Rehabilitative medicine services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles, including

- Medical rehabilitation – includes but not limited to cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic and Osteopathic mechanical traction
- Biofeedback for treatment of medical diagnosis when Medically/Clinically Necessary, as determined according to BCN medical policies

We cover short term Outpatient therapy services in full after Deductible when

- Preauthorized by BCN as Medically Necessary
- Treatment is provided for an illness, injury or congenital defect for which you received corrective surgery
- Provided in an Outpatient setting
- Services are not provided by any federal or state agency or any local political subdivision, including school districts
- Results in meaningful improvement in your ability to do important day to day activities within 90 days of starting treatment

**Habilitative Services** that help a person keep, learn or improve skills and functioning for daily living are covered in full after Deductible when Preauthorized by BCN as Medically Necessary. Examples include but are not limited to:

- Therapy for a child who isn't walking or talking at the expected age
- Physical and occupational therapy, speech-language pathology and other services for people with disabilities.

### ***Benefit Maximums***

#### Rehabilitative

- Rehabilitative physical therapy/occupational therapy/mechanical traction services are limited to combined Benefit Maximum of 30 visits per Calendar Year
- Rehabilitative speech therapy services are limited to a Benefit Maximum of 30 visits per Calendar Year
- Cardiac and pulmonary rehabilitation is limited to a combined Benefit Maximum of 30 visits per Calendar Year

#### Habilitative

- Habilitative physical therapy/occupational therapy/mechanical traction services are limited to combined Benefit Maximum of 30 visits per Calendar Year
- Habilitative speech therapy services are limited to a Benefit Maximum of 30 visits per Calendar Year

### ***General Exclusions include but are not limited to***

- Cognitive therapy and retraining (neurological training and retraining)
- Services that can be provided by any federal or state agency or local political subdivision, including school districts, when the Member is not liable for the costs in the absence of insurance
- Vocational rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return to work programs
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency
- Craniosacral therapy

- Prolotherapy
- Rehabilitation services obtained from non-Health Professionals, including massage therapists
- Strength training and exercise programs
- Sensory integration therapy

***Additional Exclusions for Speech Therapy include but are not limited to***

- Sensory, behavioral, cognitive or attention disorders
- Treatment of stuttering or stammering
- Swallowing therapy for deviant swallow or tongue thrust;
- Vocal cord abuse resulting from life-style activities or employment activities such as, but not limited to, cheerleading, coaching, singing
- Summer speech program - treatment for children who would be eligible to receive speech therapy through school or a public agency

***8.17 Durable Medical Equipment***

Durable Medical Equipment (DME) is

- Equipment used primarily for medical purposes
- Requires a prescription from the treating physician
- Is intended for repeated use
- Useful primarily because of illness, injury or congenital defect

***Coverage***

We cover rental or purchase of DME when limited to the basic equipment. Any supplies required to operate the equipment and special features must be considered Medically Necessary and Preauthorized by BCN. Items must be obtained from a DME Participating Provider.

In many instances BCN covers the same items covered by Medicare Part B as of the date of the purchase or rental. In some instances, however, BCN guidelines may differ from Medicare.

For specific coverage information and to locate a Participating DME provider, please call Customer Service at the number provided on the back of your BCN ID card.

***Cost Sharing***

50% Coinsurance of the Approved Amount after Deductible  
 Applies toward the Out-of-Pocket Maximum

NOTE: Breast pumps needed to support breast-feeding are covered in full only when Preauthorized and obtained from a DME Participating Provider (See Preventive and Early Diagnosis section)

***Limitations and Exclusions***

***Limitations include but are not limited to***

- The equipment must be considered DME under your Coverage and must be appropriate for home use
- Obtained from a BCN Participating Provider
- Prescribed by your Primary Care Physician or a Participating Provider
- Preauthorized by BCN
- The equipment is the property of the DME provider. When it is no longer Medically Necessary, you may be required to return it
- Repair or replacement, fitting and adjusting of DME are covered only when needed as determined by BCN resulting from body growth, body change or normal use
- Repair of the item if it does not exceed the cost of replacement

***Exclusions include but are not limited to***

- Deluxe equipment (such as motor-driven wheelchairs and beds, etc.) unless Medically Necessary for the Member and/or required so the Member can operate the equipment. (NOTE: If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the your option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that is prescribed.)
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bed boards, bathtub lifts, overhead tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds)
- Physician's equipment (such as blood pressure cuffs and stethoscopes)
- Disposable supplies (such as sheets, bags, ear plugs, elastic stockings)
- Over the counter supplies including wound care (such as disposable dressing and wound care supplies) in absence of skilled nursing visits in the home
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills)
- Self-help devices that are not primarily medical items (such as sauna baths, elevators, ramps, special telephone or communication devices)
- Equipment that is experimental or for research (See Section 9)
- Needles and syringes for purposes other than for treatment of diabetes
- Repair or replacement due to loss, theft, damage or damage that can be repaired
- Assistive technology and adaptive equipment such as computers, supine boards, prone standers and gait trainers
- Modifications to your home, living area, or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, swimming pools and car seats
- All repairs and maintenance that result from misuse or abuse

## **8.18 Diabetic Supplies and Equipment**

Basic Diabetic Supplies and Equipment are used for the prevention and treatment of clinical diabetes.

Diabetic supplies must be

- Medically Necessary
- Prescribed by your Primary Care Physician
- Obtained from a BCN Participating Provider

We cover in full after Deductible.

- Blood glucose monitors
- Test strips for glucose monitors, lancets and spring powered lancet devices, visual reading and urine testing strips
- Syringes and needles
- Insulin pumps and medical supplies required for the use of an insulin pump
- Diabetic shoes and inserts

Diabetic supplies and equipment are limited to basic equipment. Special features must be Medically Necessary and Preauthorized by BCN. Replacement of diabetic equipment is covered only when Medically Necessary.

Repair and replacement are covered only when needed as determined by BCN as not resulting from misuse. Repair of the item will be covered if it does not exceed the cost of replacement.

For specific coverage information and to locate a Participating provider, please call Customer Service at the number provided on the back of your BCN ID card.

### ***Exclusions include but are not limited to***

- Replacement due to loss, theft or damage or damage that can be repaired
- Deluxe equipment unless Medically Necessary. If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that is prescribed.
- Alcohol and gauze pads

## **8.19 Prosthetics and Orthotics**

### ***Definitions***

Prosthetics are artificial devices that serve as a replacement of a part of the body lost by injury (traumatic) or missing from birth (congenital).

Prosthetic devices are either:

**External:** Devices such as an artificial leg, artificial arm or the initial set of prescription

lenses for replacement of an organic lens of the eye following Medically Necessary eye surgery (e.g. cataract surgery); or

**Internal Implantable Prosthetic Devices:** Devices surgically attached or implanted during a Preauthorized surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, implanted lens immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g. cataract surgery)

**Orthotics** are artificial devices that support the body and assist in its function (e.g., a knee brace, back brace, etc.).

## **Coverage**

Prosthetics and Orthotics must be

- Medically Necessary
- Prescribed by your Primary Care Physician
- Obtained from a BCN Participating Provider

Medically Necessary special features are covered if prescribed by the treating physician, Preauthorized by BCN and obtained from a Participating Provider.

Coverage includes but is not limited to

- Implantable or non-implantable breast prostheses required following a Medically Necessary mastectomy
- Repair, replacement, fitting and adjustments are covered only when needed as determined by BCN resulting from body growth, body change or normal use. Repair of the item will be covered if it does not exceed the cost of replacement
- The initial set of prescription lenses (eyeglasses or contact lenses) are covered as a prosthetic device immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g., cataract surgery)

In many instances, BCN covers the same items covered by Medicare Part B as of the date of the purchase or rental. In some instances, however, BCN guidelines may differ from Medicare.

For specific coverage information and to locate a Participating provider, please call Customer Service at the number provided on the back of your BCN ID card.

## **Cost Sharing**

### **External Prosthetic Devices and Orthotics**

50% Coinsurance of the Approved Amount after the Deductible  
Applies toward the Out-of-Pocket Maximum

### **Internal Implantable Prosthetic Devices**

Your Inpatient, Outpatient or office visit Benefit applies  
Applies to the Out-of-Pocket Maximum

### **Limitations**

- The item must meet the Coverage definition of a Prosthetic or Orthotic device
- It must be Preauthorized by BCN
- You must obtain the item a BCN-approved supplier
- The Primary Care Physician or a Participating Provider must prescribe the item
- Coverage is limited to the basic items. If a deluxe item is requested, the Approved Amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the Approved Amount designated by BCN for the different type of item that is prescribed
- Any special features that are considered Medically Necessary must be Preauthorized by BCN
- Replacement is limited to items that cannot be repaired or modified

### **Exclusions include but are not limited to**

Repair or replacement made necessary because of loss, theft or damage caused by misuse or mistreatment is not covered. Also excluded, by example and not limitation, are the following:

- Sports-related braces
- Dental appliances, including bite splints
- Hearing aids; including bone anchored hearing devices
- Eyeglasses or contact lenses (except after lens surgery as listed above)
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, wigs and hairpieces
- Over the counter arch supports, foot orthotics
- Shoe inserts that are not attached to leg brace
- Over the counter supplies and disposable supplies such as compression stocking
- Devices that are experimental and research in nature
- Items for the convenience of the Member or care giver
- Repair or replacement due to loss, theft, damage or damage that cannot be repaired
- Duplicate appliances and devices

### **8.20 Organ and Tissue Transplants**

We cover organ or body tissue transplant in full after Deductible when

- It is considered non-experimental in accordance with generally accepted medical practice
- It is Medically Necessary
- Preauthorized by BCN
- It is performed at a BCN-approved transplant Facility

NOTE: For a Preauthorized transplant, BCN also covers the necessary Hospital, surgical, laboratory and X-ray services for a non-Member donor, unless the non-Member donor has coverage for such services.

### **Exclusions include but are not limited to**

- All services for a Member donor to a non-Member recipient
- Community wide searches for a donor

## **8.21 Reconstructive Surgery**

### **Definition**

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance. Reconstructive surgery may include:

- Correction of a birth defect that affects function
- Breast reconstructive surgery following a Medically Necessary mastectomy (including treatment of cancer). This may include nipple reconstruction, surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment for physical complications resulting from the mastectomy, including lymphedema; and
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Service under this Certificate, disease, accidental injury, burns and/or severe inflammation, including but not limited to the following procedures:
  - Blepharoplasty of upper lids
  - Panniculectomy
  - Rhinoplasty
  - Septorhinoplasty

### **Coverage**

We cover reconstructive surgery in full after Deductible when it is Medically Necessary and Preauthorized by BCN.

**A) Reduction Mammoplasty (breast reduction surgery)** for females when it is Medically Necessary and Preauthorized by BCN

**B) Male Mastectomy** for treatment of gynecomastia when it is Medically Necessary and Preauthorized by BCN

## **8.22 Oral Surgery**

We cover oral surgery and X-rays in full after Deductible only when Preauthorized by BCN for

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw

- Oral surgery and dental services necessary for **immediate** repair of trauma to the jaw, natural teeth, cheeks, lips, tongue, roof and floor of the mouth  
NOTE: “Immediate” means treatment within 72 hours of the injury. Any follow-up treatment performed after the first 72 hours post-injury is not covered
- Anesthesia covered in an Outpatient Facility setting when Medically Necessary and Preauthorized by BCN
- Medically Necessary surgery for removing tumors and cysts within the mouth

Hospital services are covered in conjunction with oral surgery when it is Medically Necessary for the oral surgery to be performed in a Hospital setting.

***Exclusions include but not limited to***

- Anesthesia administered in an office setting
- Rebuilding or repair for cosmetic purposes
- Orthodontic treatment even when provided along with oral surgery
- Surgical preparation for dentures
- Routine dental procedures
- Surgical placement of dental implants including any procedures in preparation for the dental implant such as bone grafts

See Section 9 for additional exclusions.

***8.23 Temporomandibular Joint Syndrome (TMJ) Treatment***

***Definition***

TMJ is a condition of muscle tension and spasms related to the temporomandibular joint, facial and/or cervical muscles that may cause pain, loss of function and/or physiological impairment.

***Coverage***

We cover medical services and treatment for TMJ when Medically Necessary and Preauthorized by BCN.

- Office visits for medical evaluation and treatment
- Specialty referral for medical evaluation and treatment
- X-rays of the temporomandibular joint, including contrast studies
- Surgery to the temporomandibular joint including, but not limited to, condylectomy, meniscectomy, arthrotomy and arthrocentesis

**Important:** Dental services are not covered.

***Cost Sharing***

50% Coinsurance of the Approved Amount after Deductible of all fees associated with Facility, professional and related services

Applies to the Out-of-Pocket Maximum

**Exclusions include but are not limited to**

- Dental and orthodontic services, treatment, prostheses and appliances for or related to TMJ treatment
- Dental appliances, including bite splints
- Dental X-rays

## **8.24 Orthognathic Surgery**

### **Definition**

Orthognathic surgery is the surgical correction of skeletal malformations involving the lower or upper jaw. A bone cut is usually made in the affected jaw and the bones are repositioned and realigned.

### **Coverage**

We cover the services listed below in full after the Deductible when Medically Necessary and Preauthorized by BCN.

- Office consultation with Specialist Physician
- Cephalometric study and X-rays
- Orthognathic surgery
- Postoperative care
- Hospitalization – only when it is Medically Necessary to perform the surgery in a Hospital setting.

**Exclusions include but are not limited to**

- Dental or orthodontic treatment (including braces), prostheses and appliances for or related to treatment for orthognathic conditions

## **8.25 Weight Reduction Procedures**

We cover surgery and procedures for weight reduction when these conditions are met

- The BCN medical criteria and established guidelines related to the procedure
- The procedure is Preauthorized by BCN as Medically Necessary

### **Cost Sharing**

50% Coinsurance of the BCN Approved Amount after the Deductible of all fees associated with Facility, professional and all related services

Applies toward the Out-of-Pocket Maximum

### **Benefit Maximum:**

Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary as determined by BCN

## **8.26 Prescription Drugs and Supplies**

### **A) Prescription Drugs Received while you are an Inpatient**

We cover prescription drugs and supplies that are prescribed and received during a Covered Inpatient Hospital stay as medical benefits.

### **B) Cancer Drug Therapy**

We cover cancer drug therapy and the cost of administration. The drug must be approved by the U. S. Food and Drug Administration (FDA) for cancer treatment.

Coverage is provided for the drug, regardless of whether the cancer is the specific cancer the drug was approved by the FDA to treat, if all of the following conditions are met:

- The treatment is Medically Necessary and Preauthorized by BCN
- The drug is ordered by a physician for the treatment of cancer
- The drug is approved by the FDA for use in cancer therapy
- The physician has obtained informed consent from the Member or their representative for use of a drug that is currently not FDA approved for that specific type of cancer
- The drug is used as part of a cancer drug regimen
- The current medical literature indicates that the drug therapy is effective, and recognized cancer organizations generally support the treatment

Cancer Drug Therapy - Covered in full after Deductible  
Cost of Administration - Covered in full after Deductible

**Coordination of Benefits for cancer therapy drugs:** If you have BCN Prescription Drug Rider, drugs for cancer therapy that are self-administered will be covered by your BCN Prescription Drug Rider before Coverage under this Certificate will apply.

### **C) Injectable Drugs**

The following drugs are covered as medical benefits:

- Injectable and infusible drugs administered in a Facility setting
- Infusible drugs requiring administration by a health professional in a medical office, home or Outpatient Facility

We may require selected Specialty Drugs be obtained by your Provider through a Specialty Pharmacy.

Selected injectable drugs in certain categories and drugs that are not primarily intended to be administered by a health professional are covered only if you have a BCN Prescription Drug Rider attached to this Certificate.

### **Exclusions include but are not limited to**

Drugs that are intended to be self-administered as defined by the Food and Drug Administration are not covered under your medical benefit. This includes self-administered drugs for certain diseases, such as arthritis, hepatitis, multiple sclerosis, and for certain other illnesses or injuries. Self-administered drugs are covered only when you have a BCN Prescription Drug Rider.

## **D) Outpatient Prescription Drugs**

We do not cover prescription drugs and supplies unless you have a BCN Prescription Drug Rider attached to this Certificate. (See Section 9)

### **8.27 Clinical Trials**

#### **Definition**

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

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

Clinical Trials of experimental drugs or treatments proceed through four phases:

- **Phase I:** Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients.
- **Phase II:** The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety.
- **Phase III:** If a treatment has shown to be effective in Phase II, it is subjected to additional scrutiny in Phase III. In this phase, the sample size of the study population is increased to between 1,000 and 3,000 people. The goals in Phase III are to confirm the effectiveness noted in Phase II, monitor for side effects, compare the study treatment against current treatment protocols, and collect data that will facilitate safe use of the therapy or treatment under review.
- **Phase IV:** These studies are done after the drug or treatment has been marketed or the new treatment has become a standard component of patient care. These studies continue testing the study drug or treatment to collect information about their effect in various populations and any side effects associated with long-term use. Phase IV studies are required by the Food and Drug Administration (FDA) when there are any remaining unanswered questions about a drug, device or treatment.

**Experimental or Investigational** is a service that has not been scientifically demonstrated to be as safe and effective for treatment of the Member's condition as conventional or standard treatment in the United States.

**Life-threatening Condition** means any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted.

**Qualified Individual** means a Member eligible for Coverage under this Certificate who participates in an Approved Clinical Trial according to the trial protocol for treatment of cancer or other –life-threatening disease or condition and either:

- The referring provider participated in the trials and has concluded that the Member's participation in it would be appropriate because the Member meets the trial's protocol; or
- The Member provides medical and scientific information establishing that the Member's participation in the trial would be appropriate because he/she meets the trial's protocol.

**Routine Patient Costs** means all items and services related to an approved clinical trial if they are covered under this Certificate or any attached Riders for Members who are not participants in an Approved Clinical Trial. They do not include:

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

## Coverage

We cover the routine costs of items and Services related to Phase I, Phase II, Phase III and Phase IV Clinical Trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. Experimental treatment and Services related to the Experimental treatment are covered after Deductible when all of the following are met:

- BCN considers the Experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for)
- The treatment is covered under your Certificate and attached Riders when it is provided as conventional treatment
- The Services related to the Experimental treatment are covered under this Certificate and attached Riders when they are related to conventional treatment
- The Experimental treatment and related Services are provided during BCN-approved oncology clinical trial (check with your provider to determine whether a Clinical Trial is approved by BCN)

**NOTE:** This Certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

***Limitations and exclusions include but are not limited to***

- The Experimental or Investigational item, device or Service itself
- Experimental treatment or Services related to Experimental treatment , except as explained under “Coverage” above
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Administrative costs related to Experimental treatment or for research management; or
- Coverage for Services not otherwise covered under this Certificate
- Drugs or devices given to you during a BCN approved oncology clinical trial are covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of your condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.
- Complications resulting from an Experimental procedure

## **SECTION 9: Exclusions and Limitations**

This section lists many exclusions and limitations. Please refer to a specific service in Section 8 for more exclusions and limitations.

### **9.1 *Unauthorized and Out of Network Services***

Except for Emergency care as specified in Section 8 health, medical and hospital services are covered **only** when:

- Provided by a BCN Participating Provider
- Preauthorized by BCN for select services
- Determined to be Medically Necessary

Any other services will not be paid for by BCN either to the provider or to the Member.

### **9.2 *Services Received While a Member***

We will only pay for Covered Services you receive while you are a Member, covered under this Certificate, and attached Riders. A Service is considered to be received on the date on which services or supplies are provided to you. We can collect from you all costs for Covered Services that you receive and we pay for after your Coverage terminates, plus our cost of recovering those charges (including attorney's fees).

### **9.3 *Services that are not Medically Necessary***

Services that are not Medically Necessary are not covered, unless specified in this Certificate. The Medical Director makes the final determination of Medical Necessity based upon BCN internal medical policies.

### **9.4 *Non-Covered Services***

We do not pay for

- Services that do not meet the terms and guidelines of this Certificate
- Office visits, exams, treatments, tests and reports for any of the following:
  - Employment
  - Insurance
  - Travel (immunizations for purposes of travel are a covered benefit)
  - Licenses and marriage license applications
  - Legal proceedings such as parole, court and paternity requirements
  - School purposes, camp registrations, or sports physicals
  - Educational and behavioral evaluations performed at school
  - Completion or copying of forms or medical records, medical photography charges, interest on late payments, and charges for failure to keep scheduled appointments
- Expenses of travel and transportation and/or lodging, except for covered Ambulance services
- Autopsies

- Employment related counseling
- Modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities
- Fees incurred for collections, processing and storage of blood, cells, tissue, organs or other bodily parts in a family, private or public bank or other Facility without immediate medical indication
- Testing to determine legal parentage
- Services performed by a provider with your same legal residence
- Services performed by a provider who is a family member
- Food, dietary supplements and metabolic foods
- Private duty nursing
- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
- Services outside the scope of the practice of the servicing provider
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures.

### **9.5 Cosmetic Surgery**

Cosmetic surgery is surgery primarily to improve appearance or self-esteem. It does not correct or materially improve a physiological function.

We do not pay for  
Including but not limited to

- Cosmetic surgery
- Elective rhinoplasty
- Spider vein repair
- Breast augmentation
- Any related services such as pre-surgical care, follow-up care and reversal or revision of the surgery

### **9.6 Prescription Drugs**

We do not pay for

- Outpatient prescription drugs
- Over-the-counter drugs or products
- Any medicines incidental to Outpatient care except as defined in Section 8

However, you may have an Outpatient prescription drug Rider issued to you that allows Coverage.

## **9.7 Military Care**

We do not cover any diseases or disabilities connected with military service if you are legally entitled to obtain services from a military Facility, and such a Facility is available within a reasonable distance.

## **9.8 Custodial Care**

We do not pay for Custodial Care that is primarily for maintaining your basic need for food, shelter, housekeeping services and clothing. This means that Custodial Care is not covered in your home, a nursing home, residential institution or any other setting that is not required to support medical and Skilled Nursing Care.

## **9.9 Comfort Items**

We do not pay for

- Personal comfort
- Convenience items
- Telephone
- Television or similar items

## **9.10 Mental Health/Substance Abuse**

We do not pay for

- Care provided by Non-Participating facilities except for emergency admissions to the point of stabilization
- Psychoanalysis and open-ended psychotherapy
- Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living (ADL) or to keep from continuing unhealthy activities
- Transitional living centers such as three-quarter house or half-way house, therapeutic, boarding schools, domiciliary foster care and milieu therapies such as wilderness programs, other supportive housing, and group homes
- Maintenance treatments for caffeine and opiate addiction
- Treatment of Chronic illnesses is limited to:
  - Treatment that is Medically Necessary to prevent an Acute episode of Chronic illness
  - Treatment of Acute exacerbation of Chronic illness (any level of care, subject to other exclusions).
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment
- Treatment programs that have predetermined or fixed lengths of care Court ordered examinations, tests, reports or treatments that do not meet requirements for Mental Health or Substance Abuse coverage
- Marital counseling services

- Sexual/gender identity disorder issues
- Services for mental disorders according to generally accepted professional standards are not amenable for favorable modification, such as certain personality disorders or certain types of intellectual impairment
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider
- Gambling addiction issues
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes are not covered as separate charges

### **9.11 Court Related Services**

- We do not cover pretrial and court testimony, court-ordered exam, or the preparation of court-related reports that do not meet health care Coverage requirements.
- We do not cover court-ordered treatment for substance abuse or mental illness except as specified in Sections 8.
- We shall not be liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member being engaged in an illegal occupation.

### **9.12 Elective Procedures**

We do not pay for

- Reversal of a surgical sterilization for males and females
- Treatment for infertility including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF) procedures, such as GIFT – gamete intrafallopian transfer or ZIFT -zygote intrafallopian transfer and all related services
  - Any other assisted reproduction procedure
  - Fees to surrogate parent
  - Prescription drugs designed to achieve pregnancy
  - Harvest preservation and storage of eggs or sperm
- Services for gender reassignment including but not limited to:
  - Gender reassignment surgery, reversal of prior gender reassignment surgery or any other surgical procedures related to gender identity disorder

- All gender reassignment services including hospital admissions, facility and professional services including hormonal therapy drug, the injection of the drug or other services to administer the drug
- Genetic testing and counseling for non-Members
- All services and supplies relating to Elective Abortion (unless covered by an applicable Rider)

### **9.13 Maternity Services**

We do not pay for

- Services and supplies provided by a lay-midwife for home births
- All services provided to non-Member surrogate parents
- Lamaze, parenting or other similar classes

### **9.14 Dental Services**

We do not pay for dental services including but not limited to

- Routine dental services and procedures
- Diagnose or treat of dental disease
- Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures
- Restoration or replacement of teeth
- Orthodontic care
- X-rays or anesthesia administered in the dental office for dental procedures even if related to a medical condition or treatment, except as specifically stated in Section 8
- Initial evaluation and services when obtained later than 72 hours after the injury or traumatic occurrence
- Prosthetic replacement of teeth that had been avulsed or extracted as a result of a trauma
- Repair of damage to fixed or removable bridges, dentures, veneers, bondings, laminates or any other appliance or prosthesis placed in the mouth or on or about the teeth

### **9.15 Services Covered Through Other Programs**

We do not pay for

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or Certificate
- Under any other policy, program, contract, or insurance as stated in *General Provisions*, Section 2 “Other Party Liability”. (The General Provisions chapter describes the rules of your health care coverage.)
- Under any public health care, school, or public program supported totally or partly by State, Federal or Local governmental funds except where BCN is made primary by law.

The following are excluded to the extent permitted by law:

- Services and supplies provided in a Non-Participating Hospital owned and operated by any Federal, State or other governmental entity

- Services and supplies provided while in detention or incarcerated in a facility such as youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment
- Services and supplies under any contractual, employment or private arrangement, (not including insurance), that you made that promises to provide, reimburse, or pay for health, medical or Hospital services
- Emergency Services paid by foreign government public health programs
- Any services whose costs are covered by third parties (including, but not limited to, employer paid services such as travel inoculations and services paid for by research sponsors)

### **9.16 Alternative Services**

We do not pay for alternative services.

Alternative treatments are not used in standard Western medicine. It is not widely taught in medical schools.

Services include but are not limited to

- Acupuncture
- Hypnosis
- Biofeedback
- Herbal treatments
- Massage therapy
- Therapeutic touch
- Aromatherapy
- Light therapy
- Naturopathic medicine (herbs and plants)
- Homeopathy
- Yoga
- Traditional Chinese medicine

Evaluations and office visits related to alternative services are not covered.

### **9.17 Vision Services**

We do not pay for

- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Routine non-Medically Necessary vision exam and optometric exams
- Refractions, unless Medically Necessary
- Glasses, frames and contact lenses except as defined in this Certificate;
- Dilation
- Visual training
- Dyslexia treatment

## **9.18 Hearing Aid Services**

We do not pay for

- Audiometric examination to evaluate hearing and measure hearing loss including, but not limited to, tests to measure hearing acuity related to air conduction, speech reception threshold, speech discrimination and/or a summary of findings
- Hearing aid evaluation assessment test or exams to determine what type of hearing aid to prescribe to compensate for loss of hearing
- Hearing aid(s) to amplify sound and improve hearing
- Conformity evaluation test to verify receipt of the hearing aid, evaluate its comfort, function and effectiveness or adjustments to the hearing aid
- Bone anchored hearing devices or surgically implanted bone conduction hearing aid

## **9.19 Out of Area Services**

Except as otherwise stated, Services under this Certificate are covered only in the BCN Service Area.

Services received outside of Michigan are administered through BlueCard®, a Blue Cross® and Blue Shield® Association program. Please refer to the attached BlueCard Rider for specific details. It tells you what you must pay under the exclusions and limitations of this Rider.

Non-routine services through BlueCard must be Preauthorized by BCN and must follow all BCN Coverage provisions.

For more information about Out-of-Area Services go to [bcbsm.com](http://bcbsm.com) or call Customer Service at the number shown on the back of your BCN ID card.