Blue Care Network
Certificate of Coverage
Blue Elect Plus℠ POS for Small Groups

This Certificate of Coverage (Certificate) describes the Benefits provided to you and is a contract between you as an enrolled Member and Blue Care Network of Michigan (BCN). It includes General Provisions and Your Benefits.

BLUE ELECT PLUS℠ POS is a product of BCN, an independent corporation operating under a license from the Blue Cross® and Blue Shield® Association. This Association is made 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.

BCN issues this Certificate and any attached Riders to you. It is an agreement between you as an enrolled Member and BCN.

By choosing to enroll as a BCN Member, you, agree to the rules as stated in the General Provisions and Your Benefits chapters.

Your Coverage is offered by your employer. Your eligibility and Benefits are subject to the contract made between your employer and BCN. You are entitled to the Services and Benefits described in this Certificate and any attached Riders in exchange for premiums paid to BCN.

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

Blue Care Network Customer Service Department
P.O Box 32136
Detroit, MI 48232-0136
800-662-6667
https://www.bcbsm.com/

BEPSM
Effective Date: 1/1/2027
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Definitions

These definitions will help you understand the terms that we use in this Certificate. They apply to the entire Certificate. Other terms are defined in later sections as necessary. In addition to these terms, use of terms "we", "us" and "our" refer to BCN or another entity or person BCN authorizes to act on its behalf. The terms "you" or "your" refer to the Member who is 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 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 as an exacerbation of disease and is expected to last a short period 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 is when a provider bills you for the difference between their charge for a Covered Service and the Approved Amount. A BCN Participating Provider may not balance bill you for Covered Services.

Benefit is a covered healthcare service that your plan helps pay for as described in this Certificate.

Blue Care Network (BCN) is the Michigan health maintenance organization in which you are enrolled. The reference to Blue Care Network may include another entity or person Blue Care Network authorizes to act on its behalf.

Calendar Year is a period 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 the enrollment form and any Riders 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. This amount is determined based on the Approved Amount at the time the claims are processed or reprocessed, and are not altered by an audit, recovery and are not reduced by any coupon, rebate or other credit received directly or indirectly from an assistance program. However, you may be able to take advantage of BCN-approved special coupon programs to help you pay some or all of your Coinsurance.

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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 the Member's right to choose, in certain circumstances, to continue receiving services from a physician or Facility that ends its 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 healthcare services. For example, your emergency room Copay might be higher than your office visit Copay. The Copay applies toward your Out-of-Pocket Maximum.

Cost Sharing (Deductible, Copayment and Coinsurance) is the portion of healthcare costs you owe as defined in this Certificate and attached Riders. BCN pays 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. The services must be ordered or performed by a Provider that is legally authorized or licensed to order or perform the service.

Custodial Care is care primarily used to help you 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 healthcare services before we pay. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed or reprocessed, and are not altered by an audit, recovery and are not reduced by any coupon, rebate or other credit received directly or indirectly from an assistance program. However, you may be able to take advantage of BCN-approved special coupon programs to help you pay some or all of your Deductible. Your Deductible amount is added or amended when a Rider is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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 or 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)

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Elective Abortion is the intentional use of an instrument, or other substance or device to terminate a pregnancy that does not meet non-elective abortion guidelines as defined in Section 8 (Reproductive Care and Family Planning section).

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

Enrollment is the process of you giving your information to your employer and the employer sending it to us.

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

Facility is a Hospital, clinic, free-standing center, urgent care center, dialysis center, etc. that provides specialized treatments devoted primarily to diagnosis, treatment, care or rehabilitation due to illness or injury.

Family Dependent is an eligible family member who is enrolled with BCN for healthcare Coverage. A Family Dependent includes Dependent Children and a Dependent Under a Qualified Medical Child Support Order. It does not include a Principally Supported Child. Family Dependents must meet the requirements stated in Section 1.

General Provisions is Chapter 1 that describes the rules of your healthcare 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 3.4.

Group is your employer or other entity that has entered into a contract to provide healthcare for its eligible members.

Habilitative Services are healthcare services 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 outpatient settings.

Hospital is an Acute Care Facility that is fully licensed and certified as required by law and complies with all applicable national certification and accreditation standards. This facility provides continuous, 24-hour Inpatient medical, surgical or obstetrical care and outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons. Hospital services are provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses. 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 use disorder, psychiatric disorders or pulmonary tuberculosis.

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In-Network Benefits are Covered Services that are provided by a Participating Provider or Facility. In-Network Benefits are paid at a higher rate than Out-of-Network Benefits.

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

Inter-Plan Programs link participating healthcare providers and the independent Blue Cross Blue Shield companies across the country for claims processing and reimbursement. These programs are subject to Blue Cross® and Blue Shield® Association policies and the rules set forth in this Certificate of Coverage. It allows BCN to have a variety of relationships with other Blue Cross and Blue Shield Licensees to process claims incurred in other states through the applicable Blue Cross® and Blue Shield® Plan.

Long-Term Acute Care Hospital is a specialty hospital that focuses on treating members requiring extended intensive care. The hospital must meet certification and accreditation standards.

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 healthcare services provided to the Member according to evidence-based clinical practice guidelines (proven to be safe and effective based on current research) 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; "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease or its symptoms
- Not primarily for the convenience of the Member or healthcare 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
- Rendered in accordance with BCN Utilization Management Criteria

Medically Necessary Drug is a drug that must be Medically Necessary to be covered, as determined by pharmacists and physicians acting for BCN, based on criteria and guidelines developed by pharmacists and physicians for BCN. The Covered Drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the

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Member or physician. In the absence of established criteria, Medical Necessity will be determined by pharmacists and physicians according to accepted standards and practices.

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.

Non-Participating Provider is an individual, Facility, or other healthcare entity not under contract with BCN. Non-Participating Providers must be appropriately licensed to perform the Covered Health Service provided. Non-Participating Providers are not listed in the BCN provider Directory. Services provided by a Non-Participating Provider are subject to the Out-of-Network Benefits unless otherwise stated in this Certificate. If a specific service requires Prior Authorization and such authorization is not received from BCN, the Non-Participating Provider may bill you for the service and you will be responsible for the entire bill.

Observation Care consists of clinically appropriate services that include testing, 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.

Online Visit is a structured real-time online health consultation using secure audio-visual technology to connect with a professional provider or BCN select on-demand virtual care vendor. The Member initiates the medical or behavioral health evaluation. The Online Visit is for the purpose of diagnosing and providing medical or behavioral health treatment for low-complexity non-emergent conditions within the provider's scope of practice.

Open Enrollment Period is the period set each year when eligible people may enroll or disenroll in BCN.

Out-of-Network Benefits are Covered Services that are provided by a Non-Participating Physician or other Non-Participating provider in an office or Facility. Out-of-Network Benefits apply higher Cost-Sharing than In-Network Benefits and may be subject to Balance Billing. (unless otherwise noted).

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 healthcare that we do not cover. Any coupon, rebate or other credits received directly or indirectly from an assistance program may not be applied to your Out-of-Pocket Maximum. Out-of-Pocket Maximum amount may be amended when a Rider is attached.

Participating or Participating Provider means an individual Provider, Facility or other healthcare entity that is contracted and credentialed with BCN to provide you with Covered Services. The Participating Provider agrees not to seek payment from you for Covered Services except for permissible Cost-Sharing.

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Patient Protection Affordable Care Act ("PPACA") also known as the Affordable Care Act, is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010.

Point of Service (POS) is a managed care plan that allows you the choice to seek services from either Participating or Non-Participating Providers as reflected in this Certificate. You will pay higher Cost Sharing for services received from Non-Participating Providers and may be subject to Balance Billing.

Preauthorization, Prior Authorization or Preauthorized Service is healthcare Coverage that is authorized or approved by your Primary Care Physician (PCP) or BCN or both 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 that must be paid for healthcare Coverage. Your employer usually pays it monthly based on its contract with BCN. This amount may include employee contributions.

Preventive Care is care designed to maintain health and prevent diseases or conditions at an early age when treatment is likely to work best. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

Primary Care Physician (PCP) is the Participating Provider you choose to provide or coordinate all of your medical healthcare, including specialty and Hospital care. The Primary Care Physician is 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 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 stated in Section (1). **NOTE:** A Principally Supported Child is not the same as a Dependent Child.

Professional Services are services performed by licensed practitioners for Covered Services based on their scope of practice. Types of practitioners include but not limited to:

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Chiropractic (DC)

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- Physician Assistant (PA)
- Certified Nurse Practitioner (CNP)
- Licensed Psychologist (LP)
- Limited License Psychologist (LLP)
- Licensed Professional Counselor (LPC)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Certified Nurse Midwife (CNM)
- Licensed Behavior Analyst (LBA)
- Clinical Nurse Specialist – Certified (CNS-C)
- Board Certified Athletic Trainers (BCAT)
- Licensed Genetic Counselor (LGC)
- Other providers as identified by BCN

Rehabilitation Services are healthcare 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.

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 this Certificate that describes any changes (addition, modifications, deletion or revision) to Coverage. A Rider also applies or amends Cost Sharing and Benefit 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 a geographical 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 Providers are located in the Service Area.

Skilled Nursing Facility is a state-licensed and certified subacute inpatient medical treatment center that provides continuous skilled nursing and other healthcare services by or under the supervision of a physician and a registered nurse. These health-related services in this facility are

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provided to Members who do not require hospitalization, but are in need of skilled nursing care and the necessary equipment to provide the treatment needed for the Member's level of care.

Skilled care services must be:

- Performed by qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists, and speech pathologists. The services 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 results
- Ordered by the attending physician
- Medically Necessary according to generally accepted medical standards
    - Examples include but are not limited to -
        - intravenous medication (including administration)
        - complex wound care

Skilled Care does not include private duty nursing, respite care or other supportive or personal care Services such as administration or routine medications, eye drops or ointments.
Subscriber is the eligible person who has enrolled for healthcare Coverage with BCN. This person's employment is the basis for Coverage eligibility. This person is also referred to as the "Member". **NOTE:** See Section 1 for eligibility requirements.

Surprise Billing is an instance where a Member unknowingly receives care from a Non-Participating Provider or receives care from a Non-Participating Provider because a Participating Provider is unavailable and later receives an unexpected bill for the difference between what the provider charges and what we pay. See Surprise Billing section under Chapter 1 for more about laws that protect you from Surprise Billing.

Telemedicine is a secure real-time healthcare service, delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Telemedicine visits are for the purpose of treating an ongoing condition that is expected to result in multiple visits before the condition is resolved or stabilized. Contact for these services must be initiated by you or your provider and must be within your provider's scope of practice for both medical and behavioral health services.

Urgent Care Center is a Facility that provides services as 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 healthcare 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 and the Group. Certain requirements depend on whether you are a:

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

1.1 Group Subscribers

Eligibility

A Group Subscriber must do all of the following:

- Be an active employee or eligible retiree of a Group
- Meet the Group's eligibility requirements
- Meet BCN's underwriting policies

Enrollment

You must enroll within 31 days of becoming eligible or during an Open Enrollment Period.

NOTE: If you decline enrollment because of having other coverage, and that coverage ends, you may enroll if any COBRA coverage is exhausted, or the other coverage was terminated as a result of loss of employer contributions or loss of eligibility.

You must request enrollment within 31 days after the other coverage ends.

Effective Date

The effective date of Coverage depends on the contract between the Group and BCN.

1.2 Family Dependent

Eligibility

A Family Dependent may be:

- The legally married spouse of the Subscriber and who meets the Group's eligibility requirements
- A Dependent Child - a Subscriber's child including natural child, stepchild, legally adopted child or child placed for adoption or foster child placement by an agency or court order. The Dependent Child's spouse is not covered under this Certificate. The Dependent Child's children may be covered in limited circumstances.

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NOTE: Newborn children, including grandchildren, may qualify for limited benefits immediately following their birth even if they are not listed on your contract. If the member who gave birth to the newborn is covered under this contract, see maternity care in the Inpatient Hospital Services section of this Certificate.

- 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 they turn 26. The child's BCN membership terminates at the end of the Calendar Year in which they turn 26.

Exception: An unmarried Dependent Child and a Dependent Under a Qualified Medical Child Support Order who becomes 26 while enrolled and who is totally and permanently disabled may continue healthcare 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 disability began before their 26th 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 31 days of the end of the Calendar Year in which the dependent child turns 26.

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

NOTE: A Dependent Child whose only disability is a learning disability or substance use disorder does not qualify for healthcare Coverage under this exception.

Enrollment

All eligible Family Dependents may be added to the Subscriber's contract as follows:

- During the annual Open Enrollment Period
- When the Subscriber enrolls
- Within 31 days of a "qualifying event," that is, birth, marriage, placement for adoption, qualified medical child support order or foster care placement.

  NOTE: See below for additional requirements for Dependents Under a Qualified Medical Child Support Order
- Adopted children are eligible for healthcare Coverage from the date of placement.

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

If the eligible Family Dependents were not enrolled because of other coverage, and they lose their coverage, the Subscriber may add them within 31 days of their loss of coverage with supporting documentation.

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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 31 days of the event.
- If the Family Dependent is not enrolled within 31 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 31 days, Coverage will be effective when the previous coverage lapses. If you do not notify BCN within 31 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.

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 your Group representative or Customer Service at the number shown on the back of your BCN ID card or see Section 7 Obtaining Additional Information.

Enrollment

The child may be enrolled at any time, preferably within 31 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.
- 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 31 days of the court or administrative order, Coverage is effective as of the date of the order.
- If BCN receives notice longer than 31 days after the order is issued, Coverage is effective on the date BCN receives notice.

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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 related to the Subscriber by blood or marriage (for example, grandchild, niece or nephew)
- Be less than 26 years of age
- Be unmarried
- Live full-time in the home with the Subscriber
- Not be eligible for Medicare or other group Coverage
- Be dependent on the Subscriber for principal financial support in accordance with Internal Revenue Service standards, and have met these standards for at least six (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 six (6) months. Coverage will begin three (3) months after the application is accepted by BCN.

To apply, you must furnish:

- Evidence that the child was reported as a dependent on the Subscriber's most recently filed tax return, or evidence of a sworn statement that the child qualifies for dependent tax status in the current year
- Proof of eligibility if we request it

Effective Date of Coverage

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

1.5 Additional Eligibility Guidelines

The following guidelines apply to all Members:

- **Medicare**: If you become eligible to enroll in Medicare, you are eligible to enroll in only the applicable Medicare program except when Medicare is secondary payer by law.
- **NOTE:** If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this Certificate. This Certificate is not a Medicare 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, you will need to switch to an applicable BCN Medicare plan. If this Certificate is maintained, you will be responsible for the cost Medicare would have paid and you will incur larger out of pocket costs.
- **Change of Status**: You agree to notify BCN within 31 days of any change in eligibility status of you or any Members on the Contract. When you are no longer eligible for Coverage, you are responsible for payment for any services or benefits.

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- We will only pay for Covered Services you receive when you are a BCN covered Member 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

With limited exceptions as stated in this Certificate, BCN does not pay claims or coordinate Benefits for Services that:

- Are not provided or Preauthorized by BCN
- Are not Covered Services under this Certificate

It is your responsibility to provide complete and accurate information when requested by us to administer Section 2. Failure to provide requested information, including information about other coverage may result in a denial of claims. If claims are denied due to your failure to update this information, the service will be considered a noncovered benefit and you may be responsible for the full amount of your provider's charges.

2.1 Non-Duplication

- BCN Coverage provides you with the Benefits for healthcare 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 provider are 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 the 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.

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- 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 paid or 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 must always be followed for auto or work-related injuries. Failure to follow the applicable Preauthorization and or Coverage requirements may leave you solely responsible for the cost of any services received.

2.3 Coordination of Benefits

We coordinate Benefits payable under this Certificate per Michigan's Coordination of Benefits Act.

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.

Provisions per Michigan's Coordination of Benefits Act (MCL 550.253)

Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans

(1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The health plan that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.

(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. A health plan that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.

(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.

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(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the health plan that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the health plan that issued the primary plan.

Order of Benefit Payments

(2) The order in which benefits are payable by health plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(i) Except as otherwise provided in subparagraph (ii), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.

(ii) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395lll, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(i) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the health plan that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no healthcare coverage for the dependent child's healthcare expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the health plan has actual knowledge of the terms of the court order or judgment.

(B) If a court order or judgment states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the order of benefits is determined in the manner prescribed in subparagraph (i).

(C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).

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(D) If there is no court order or judgment allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows, in the following order of priority:

(I) The plan covering the custodial parent.

(II) The plan covering the custodial parent's spouse.

(III) The plan covering the noncustodial parent.

(IV) The plan covering the noncustodial parent's spouse.

(iii) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (i) or (ii), as applicable, as if those individuals were parents of the child.

(iv) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (i) to the dependent child's parents, as applicable, and his or her spouse.

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.

(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.

(iii) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.

(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.

(iii) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second

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plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(i) A change in the amount or scope of a plan's benefits.

(ii) A change in the entity that pays, provides, or administers the plan's benefits.

(iii) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

Length of Time Covered under a Plan

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

Plan Inability to Agree on Order of Benefits

(4) If the health plans cannot agree on the order of benefits within 30 calendar days after the health plans have received all of the information needed to pay the claim, the health plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment. A health plan is not required to pay more than it would have paid had the plan it issued been the primary plan.

Amount to be Paid by the Secondary Plan

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the health plan that issued a secondary plan, if the health plan wishes to coordinate benefits, the health plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The health plan that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

Amount to be Paid by the Secondary Plan

(6) In determining the amount to be paid on a dental plan claim by the health plan that issued a secondary plan, if the health plan wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the health plan that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the health plan that issued the secondary plan shall make no payment. If a health plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that

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may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

Payment of Claims or Coordination of Benefits not Provided or Authorized by Health Maintenance Organization

(7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract

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:

"**Claims 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 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 to be fully compensated for their damages before any Subrogation Liens may be paid.

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"Other Equitable Distribution Principles" means any legal or equitable doctrines, rules, laws or statues 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 a representative of the injured party.

Your Responsibilities

In certain cases, BCN may have paid for healthcare services for you or other Members on the Contract, which 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 were 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 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 of 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.

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d. You agree not to compromise, settle a claim, or take any action that would prejudice the rights and interests of BCN without getting BCN's prior written consent.

e. 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. BCN will have the right to recover from you the value of services and benefits provided to you.

Section 3: Member Rights and Responsibilities

3.1 Confidentiality of Healthcare Records

Your healthcare 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 policy.

3.3 Primary Care Physician

For Michigan residents 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 able to accept you or your family members. 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").

You do not need Preauthorization from BCN or from any other person, including your Primary Care Physician, in order to obtain access to obstetrical or gynecological care from a provider who specializes in obstetrics or gynecology. The Specialist, however, may be required to comply with certain BCN procedures, including obtaining Preauthorization for certain services and

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following a pre-approved treatment plan. The Member retains the right to receive the obstetrical and gynecological services directly from their 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 healthcare professionals (including certified and registered nurse midwives) who specialize in obstetrics or gynecology is available at https://www.bcbsm.com/ or by calling Customer Service at the number shown 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 will 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 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 with 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 180 calendar days from the date of discovery of a problem to file a grievance regarding a decision by BCN. There are no fees or costs charged to you when filing a grievance.

If you are member of an ERISA (Employee Retirement Security Act) qualified group, you have the right to bring a civil action against BCN after completing the BCN internal grievance procedures under the terms applying to ERISA groups. Non-ERISA group members, including their dependents, and non-group members, including their dependents, must exhaust all grievance steps (including external review by the Department of Insurance & Financial Services) prior to filing civil action. You may obtain further information from the local U.S. Department of Labor or by contacting the Department of Insurance & Financial Services at the number and address below.

Definitions:

Adverse Benefit Determination - means any of the following:

- A request for a benefit, on application of any utilization review technique, does not meet the requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or investigational and is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit

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- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination of a covered person's eligibility for coverage.
- A determination that Surprise Billing protections are not applicable or the improper application of those protections, including the calculation of the applicable cost-share.
- A prospective or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- A rescission of coverage determination.
- Failure to respond in a timely manner to request for a determination.

Pre-Service Grievance is an appeal that you can file when you disagree with our preapproval decision for a service that you have not yet received.

Post-Service Grievance is an appeal that you file when you disagree with our decision for a service that you have already received.

Step One: Review and Decision by the Appeals and Grievance Unit

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
Blue Care Network
P. O. Box 44200
Detroit, MI 48244-0191
Fax 866-522-7345

The Appeals and Grievance Unit will review your grievance and give you our decision within 15 calendar days for Pre-Service Grievances and within 30 calendar days for Post-Service Grievances.

The person or persons who review the first-level grievance are not the same individuals involved in the initial determination. If an adverse determination is made, BCN will provide you with a written statement 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 you are dissatisfied with the determination, you may appeal to Step Two within 180-calendar days of receipt of BCN's adverse determination. You, or a person authorized in writing to act for you, must notify the Appeals and Grievance Unit in writing and at the address above of your decision to appeal. If you do not file a Step Two grievance within the 180-calendar day timeframe, your grievance is considered abandoned and no further action may be taken. The Michigan Department of Insurance & Financial Services will independently review the Adverse Benefit Determination, including determinations related to the application of Surprise Billing protections under the No Surprises Act.

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Step Two: Review and decision by a BCN Step Two Member Grievance Panel

If you appeal from Step One, BCN's Step Two Member Grievance Panel will review and reconsider the determination made at Step One. You, or someone authorized by you in writing, may present the grievance to the Step Two Member Grievance Panel in person or by telephone conference. For Pre-Service and Post-Service Grievances, notification of the Step Two grievance resolution will be sent to you within 15 calendar days for Pre-Service and 30 calendar days for Post-Service. 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. 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 will be sent within 5-calendar days of the Panel meeting, but not longer than 15-calendar days for Pre-Service and 30 calendar days for Post-Service 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 at Step Two or our internal grievance process is waived, you may appeal to the Department of Insurance & Financial Services (DIFS) at https://difs.state.mi.us/Complaints/ExternalReview.aspx or at the addresses listed below:

Office of Research, Rules, and Appeals – Appeals Section Department of Insurance & Financial Services

(By mail)
P. O. Box 30220
Lansing, MI 48909-7720

(By delivery service)
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Phone: 1-877-999-6442
Fax: 517-284-8837
Email: DIFS-HealthAppeal@michigan.gov

When filing a request for an external review, you 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 30-calendar days for Pre-Service Grievances or 60-calendar days for Post-Service Grievances (plus 10 business days if BCN requests additional medical information) from the date we receive your written grievance, you will be considered to have exhausted the internal grievance process and may request an external review. You must do so within 127 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.

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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 866-522-7345.

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 we fail to provide you with our final determination timely or you receive an adverse determination, you may request an expedited external review from DIFS within 10-calendar days of receiving our final determination. You may also file for an expedited external review at the same time you submit a request for an expedited internal review if your physician substantiates you have a medical condition such that the timeframe for completion of the expediated internal review would seriously jeopardize your life or health.

3.5 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 to 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 develop mutually agreed upon treatment goals
- Comply with the terms and conditions of the Coverage provided

3.6 Member's Role in Policy-Making

At least one third of the Board of Directors of BCN will consist of BCN Members, elected by Subscribers. BCN provides nomination and election procedures to Subscribers every 3 years.

3.7 Preauthorization Process

Some services and supplies require Preauthorization by your Primary Care Physician or BCN or both. Section 8 tells you which services and supplies need Preauthorization. You can get a complete, detailed and up-to-date list by contacting customer service or by visiting https://bcbsm.com/priorauth. The list may change from time to time.

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This chart describes the type of request, decision and notification timeframes.

Type of Request	Decision and Notification Timeframes
Prior Authorization Non-Urgent review: When you need a certain healthcare service, but it is not urgent.	Decisions can take up to seven days from receipt of the request.
Prior Authorization Urgent review: When you need to get a certain healthcare service as soon as possible, but it is not an emergency.	Decisions can take up to three days from receipt of the request.
Post Service review: When your provider submits an authorization request after you received the care you need.	Decisions can take up to 30 calendar days from receipt of the request
Urgent Concurrent review: When you are already getting care, your provider may ask us to approve additional services to assist in your treatment.	Decisions can take up to 72 hours from receipt of the request

NOTE: If we are unable to decide in the allotted timeframe because your physician has not submitted all the necessary information to review, we may take an extension allowing for more days to process and obtain the missing information. We will collaborate directly with your provider to obtain all necessary information to make the best decision.

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, as defined by PPACA, 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 BCN grievance procedure as described in Section 3 and online at https://www.bcbsm.com/importantinfo. 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. BCN may request its return at any time.

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To be entitled to Benefits, the person using the card must be the Member for whom all premiums have been paid. If the person is not entitled to receive services, 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 visiting https://www.bcbsm.com/. Information regarding how to obtain a new BCN ID card is also on our website.

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:

- Permit any other person to use your card
- Attempt to or defraud BCN

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 Group or the Member.
- 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 Coverage.
- BCN may disclose your medical information to your Primary Care Physician or other treating physicians or as otherwise permitted by law.
- 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 Copays, Coinsurance or Deductible. If, however, circumstances require you to pay a provider, you may request reimbursement for those services. Proof of payment must show exactly what services you received including diagnosis, procedure 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 https://www.bcbsm.com/. You may submit your itemized medical bills electronically through your Member online account or mail to the address below.

P. O. Box 32136
Grand Rapids, MI 48232-0136

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NOTE: Proof of payment must be submitted within 12 months of the date of service. Any claim submitted 12 months after the date of service will not be reimbursed.

Section 5: Termination of Coverage

5.1 Termination of Group Coverage

This Certificate and the contract between a Group and BCN are guaranteed renewable and will continue in effect for the period established by BCN and the Group. The agreement continues from year to year, subject to the following:

- The Group or BCN may terminate the Certificate with 30 days written notice including reason for termination. Benefits for all Members of the Group will terminate on the date the Certificate terminates; and
- If the Group terminates this Certificate, all rights to Benefits end on the date of termination to the extent permitted by law.

BCN will cooperate with the Group to arrange for continuing care of Members who are hospitalized on the termination date.

5.2 Termination for Nonpayment

Nonpayment of Premium

- If a Group fails to pay the premium by the due date, the Group is in default. BCN allows a 30-day grace period; however, if the default continues, the Group and its Members may be terminated.
- BCN will allow a 30-day grace period; however, if the Group or Member is terminated, any Covered Services incurred by a Member and paid by BCN after the date of last full payment will be charged to the Group or, as permitted by law, to the individual Member.

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 refuse to renew Coverage for any contract under either of the following conditions:

- If you fail to pay applicable Copayments, Deductible, Coinsurance or other fees within 90 days of their due date
- 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 of such termination.

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5.3 Termination of a Member's Coverage

Coverage for any Member may be terminated for any of the reasons listed below.
Such termination is subject to reasonable notice and grievance rights required by law:

- You no longer meet eligibility requirements
- Coverage is cancelled for nonpayment
- The Group's Coverage is cancelled
- You misuse your Coverage
  - Misuse includes illegal or improper use of your Coverage such as:
    - Allowing an ineligible person to use your Coverage
    - Requesting payment for services you did not receive
- You fail to repay BCN for payments we made for services that were not a benefit under this Certificate, subject to your rights under the appeal process
- You are satisfying a civil judgment in a case involving BCN
- You are repaying BCN funds you received illegally
- You are serving a criminal sentence for defrauding BCN
- Your group changes to a non-BCN health plan
- We no longer offer this Coverage
- BCN exits the small group market
- Your cessation of association membership

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. Once we notify you that we are rescinding your Coverage, we may hold or reject claims during this 30-day period. In some circumstances, fraud or intentional misrepresentation of a material fact may include:

- Misuse of the BCN ID card (Section 4)
- Intentional misuse 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 a copy of the procedure at https://www.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.

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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 became eligible for other coverage

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

Section 6: Continuation Coverage

6.1 Loss Because of Eligibility Change

If you no longer meet eligibility requirements as described under Section 1, you may transfer to an alternate benefit program offered by the Group, if any. If no alternate benefit program is available or if you are unable to meet any alternate benefit program eligibility requirements, you may apply for non-group coverage through BCN or Blue Cross® Blue Shield® of Michigan. To obtain information, you can call us at the number shown on the back of your BCN ID card.

6.2 COBRA Coverage

If you no longer meet the eligibility requirements as described under Section 1, you may be able to continue coverage at your own expense under federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act). Most employers with 20 or more employees are required by federal law to offer this coverage (continuation coverage). The employer is the administrator of its COBRA plan. If you have questions, you should contact your Group.

NOTE: Employers under 20 employees, church-related groups and federal employee groups are exempt from COBRA.

If your employer is required by COBRA to offer you the option of purchasing continuation coverage, you will need to be aware of the following conditions:

- You may apply and pay for group continuation coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
- This coverage may continue for up to 18, 29 or 36 months, depending on the reason for your initial ineligibility:
    a. You are considered a Group Member for all purposes including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
    b. Continuation coverage and all benefits cease automatically under any of the following:
        i. The period allowed by law expires
        ii. The employer no longer includes BCN as part of its Group health plan

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iii. You begin coverage under any other benefit program or health coverage plan (with some exceptions)

iv. You become eligible for Medicare

v. You do not pay for coverage fully and on time

Section 7: Additional Provisions

7.1 Notice

Any notice that BCN is required to give to you 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 your employer and BCN immediately if your address changes.

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 Coverage

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

7.6 Assignment

Benefits covered under this Certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this Certificate.

7.7 Policies

Reasonable policies, procedures, rules and interpretations may be adopted in order to administer this Certificate. Your Benefits include additional programs and services as set forth in your member account at https://www.bcbsm.com/.

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7.8 Time Limit for Legal Action

You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this Certificate, before you begin legal action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

7.9 Your Contract

Your contract consists of the following:

- Your Certificate of Coverage
- The contract between the Group and BCN
- 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 for purposes of underwriting:

- Adjust premiums based on genetic information
- 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 payment of claims. 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, Coinsurance, Copayments and Deductible under your Certificate and attached Riders.

No agent or any other person, except an officer of BCN has the authority to do either 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 any information.

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7.11 Amendments

- This Certificate and the contract between the Group and BCN are subject to amendment, modification or termination.
- Such changes must be made in accordance with the terms of this Certificate or by mutual agreement between the Group 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 or BCN personnel
- War
- Riot
- Civil insurrection
- Labor disputes not within the control of BCN.

7.13 Obtaining Additional Information

The following information is available:

- The current provider network in your Service Area
- The professional credentials of the healthcare 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 healthcare 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

You can obtain the information through these sources:

- Online at https://www.bcbsm.com/;
- By writing BCN Customer Service at P.O. Box 68767, Grand Rapids, MI 49516-8767;
- By calling our Customer Service Department at the number shown on the back of your BCN ID card; or
- By checking your BCN Welcome book

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NOTE: Some of this information may be found in your member account at https://www.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 healthcare services under this Certificate, and BCN has 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 healthcare 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 Unlicensed and Unauthorized Providers

We do not pay for services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCN), or
- Legally authorized or licensed to order or provide such services.

7.19 Special Programs

BCN has special programs where you may receive enhanced benefits, wellness program incentives or financial assistance in meeting the Cost Share requirements of your Coverage based on your eligibility or compliance with select medical services and/or taking part in a case management program. These programs may be provided by a BCN approved vendor or directly through us.

When special programs are available, you must enroll in and use the program when required by BCN or the approved vendor. For example, you may be required to enroll in and use programs

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provided by the drug manufacturers or affiliates to receive coupons or assistance for select medications.

Special programs may lower the cost typically associated with medical services and medications. Participation in certain special programs may result in you paying less than your plan Cost-Share. If you are not eligible to enroll in the program, you will pay the applicable Cost-Share for the services defined in this Certificate and associated Riders. If you are eligible and do not enroll when the special program is required, you must pay the applicable coupon amount for your medical services and medications, and this amount will not apply towards your annual Out-of-Pocket Maximum. This amount will also not apply towards your Deductible, if applicable.

> **NOTE:** When you have enrolled in the program, only the amount you pay out of pocket will apply towards your annual Out-of-Pocket Maximum.

We may terminate any special program based on:

- Your nonparticipation in the program
- Termination or cancellation of your BCN coverage
- Termination of the program
- Other factors

You may access information on these programs by contacting BCN Customer Service.

7.20 Surprise Billing

Federal and Michigan state law require us to pay Non-Participating Providers certain rates for Covered Services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, we will pay the provider directly, and you will only pay the In-Network Cost Share applicable to that service as defined in federal or Michigan law. The Cost Share you pay for these services will apply to your plan In-Network Deductible and In-Network Out-of-Pocket Maximum. The following situations are covered by the Surprise Billing laws:

- Covered Emergency Services at a Participating or a Non-Participating Facility
- Covered Non-Emergency Services provided by Non-Participating Providers in the following Participating Facilities: Hospitals, Critical Access Hospitals, Hospital Outpatient Departments, and Ambulatory Surgical Centers.
    - You can waive Surprise Billing Protections if you sign a notice and consent form.
    - Certain "ancillary" providers are not allowed to ask you to waive your Surprise Billing Protections. These include anesthesiologists, pathologists, emergency medicine providers, radiologists, neonatologists, hospitalists, and surgical assistants.
- Covered Air Ambulance Services

7.21 Experimental Treatment

We do not pay for:

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- Experimental treatment. This includes experimental drugs and devices
- Services and administrative costs related to experimental treatment
- Costs of research management

NOTE: See Clinical Trials section and Covered Services below for exceptions.

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.

How BCN Determines if a Treatment is Experimental

If a treatment is not covered under this Certificate, BCN's Medical Director will determine if it is experimental. The director may decide it is experimental if:

- Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
- It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the member's condition, or
- Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or
- It is being studied in an on-going clinical trial, or
- The treating provider uses a written informed consent that refers to the treatment as:
  - Experimental or investigational, or
  - Other than conventional or standard treatment, or
  - The Medical Director may consider other factors

How BCN Determines if a Drug is Experimental

BCBSM/BCN Pharmacy and Therapeutics (P&T) Committee determines whether a drug is experimental. The committee may decide a drug is experimental if there is insufficient evidence of a clinical benefit for the indication(s) in question. A drug may be deemed experimental if any of the following apply:

- The drug does not have unrestricted market approval from FDA for the requested use
- There is insufficient medical and scientific evidence to evaluate the therapeutic value of the drug for the requested use
- There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the drug has a beneficial effect on health outcomes; for example, when a drug does not meet its primary endpoint in a pivotal or confirmatory trial

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- The drug is not as beneficial as established alternatives or there is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the drug is as beneficial as established alternatives.

When available, these sources are considered in deciding if a treatment or drug is experimental under the above criteria:

- Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
- Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
- Accepted national standards of practice in the medical profession
- Approval by the hospital's or medical center's Institutional Review Board

NOTE: The Medical Director may consider other sources

Coverage

We do cover experimental treatment and its related services including drugs 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 services related to the experimental treatment are covered under your Certificate when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCN-approved clinical trial (check with your provider to determine whether a clinical trial is approved by BCN), or the related services are routine patient costs that are covered under "Clinical Trials" section.

Limitations and Exclusions

- This general provision does not add Coverage for services not otherwise covered under your Certificate.
- Drugs or devices given to you during a BCN-approved clinical trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, we will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

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Chapter 2 – YOUR BENEFITS

Important Information

This Certificate provides you with important information about your healthcare Benefits including Preauthorization requirements. Any attached Rider(s) provides you with additional information about your Cost-Sharing and Benefit Maximums. Read the entire Certificate and all attached Riders carefully.

- The Services listed in this chapter are covered when Services provided are in accordance with Certificate requirements and, when required, are Preauthorized or approved by BCN except in an Emergency.

- Medical Services defined in this Certificate are Covered Services only when they are Medically Necessary.

- A 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 that service.

- 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, as adopted by your Group, may be attached to this Certificate. It amends or applies Copayments, Coinsurance, Deductible, Out-of-Pocket Maximum, or Benefit Maximums.

- When a Rider is attached to this Certificate, the Rider will take precedence.

- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.

- You have other Benefits and Services like:
  - Disease management
  - Prevention
  - Wellness
  - Care management services.

You can find more details in your member account at https://www.bcbsm.com/

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- For an updated list of Services that require Preauthorization, contact Customer Service at the number shown on the back of your BCN ID card or by visiting https://bcbsm.com/priorauth.

Section 8: Your Benefits

8.1 Accessing In-Network and Out-of-Network Benefits

You have the option of obtaining Covered Services In-Network (from a Participating Provider) or Out-of-Network (from a Non-Participating Provider). All services are subject to the requirements of this Certificate in order to be Covered Services.

Michigan residents must select a BCN Primary Care Physician to provide or coordinate In-Network Covered Services.

Some services provided In-Network or Out-of-Network require Preauthorization before they are covered. You are responsible for verifying Preauthorization was obtained from BCN for services received from a Non-Participating Provider. Please refer to your BCN ID card for the appropriate telephone number to obtain Preauthorization or if you have questions about Preauthorization.

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. Benefits are payable for In-Network Covered Services that are:

- Provided or coordinated by your Primary Care Physician in the office, in the home or at a Participating Provider – either Inpatient or Outpatient – with any required Preauthorization
- Provided by a Participating Provider with any required Preauthorization, but without coordination with the Primary Care Physician
- Provided by a Non-Participating Provider when there is an insufficient number of Participating Providers for a specific provider specialty within the BCN provider network. The service must be Preauthorized by BCN for the in-network Cost Share to apply. If Prior Authorization is not received before you receive Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for paying the out-of-network Cost Sharing when received from a Non-Participating Provider.
- Emergency health services
- Urgent care center services
- Provided outside of Michigan utilizing the Inter-Plan Programs (Section 9 Out of Area Services)

NOTE: You are responsible for determining whether a provider is a Participating Provider before obtaining services. This information can be found at https://www.bcbsm.com/ or by contacting Customer Service at the number provided on the back of your BCN ID card. Unless otherwise specified in this Certificate and the surprise Billing section, we pay claims based on the status of the provider as of the date of service.

Out-of-Network Benefits are generally paid at a lower rate than In-Network Benefits or may be excluded from Coverage. You may be responsible for the difference between the BCN

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Approved Amount and the Non-Participating Provider's charge. (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference).

Out-of-Network Benefits are payable for Covered Services that are:

- Provided within the state of Michigan by a Non-Participating Provider
- Preauthorized by BCN if Preauthorization is required. For a complete list of services requiring Preauthorization, contact customer service or visit https://bcbsm.com/priorauth; select *Approving Covered Services*. For these services, coordinate the authorization through BCN and the Non-Participating Provider.
- Provided outside of Michigan without utilizing the Inter-Plan Programs (Section 9 Out of Area Services)

8.2 Cost Sharing

Deductible

A Deductible is the amount you are responsible to pay before BCN will pay for Covered Services. The Deductible renews each Calendar Year.

In the case of two or more Members on a family Contract, the Deductible paid by all Members will be combined to satisfy the Contract (Family) Deductible. **NOTE:** An individual Member cannot contribute in excess of the individual Member Deductible toward the Contract (Family) Deductible. Once an individual meets their individual Deductible, that individual will not be responsible for any additional individual Deductible for the remainder of the Calendar Year.

The Approved Amount will be applied to the Deductible for Covered Services. Charges paid by a Member in excess of the Approved Amount do not apply toward the Deductible.

Your Deductible renews each Calendar Year, but any Deductible paid during the last 3 months of the prior Calendar Year in which you were enrolled with BCN will be credited to the new Calendar Year. However, Deductible amounts carried over from one Calendar Year to the next do not count towards your Out-of-Pocket Maximum.

If you use both In-Network and Out-of-Network Benefits, separate Deductible amounts apply. The Deductible for In-Network and Out-of-Network Benefits is not combined to satisfy the Deductible limit.

NOTE: A Rider attached to this Certificate may amend your Deductible amount

DEDUCTIBLE AMOUNT	
In-Network Benefits	**Out-of-Network Benefits**
$500 per individual Member $1,000 per family Contract	$1,000 per individual Member $2,000 per family Contract

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Copayment (Copay)

You are responsible for fixed dollar Copays for many of the Benefits listed in this Certificate. You are required to pay any Copays at the time you receive the services. Copays count toward your Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum is met, you will not be responsible for Copays for the remainder of the Calendar Year.

NOTE: A Rider attached to this Certificate may amend your Copay amounts.

Coinsurance

You are responsible for a percentage of the Approved Amount (Coinsurance) for many of the Benefits listed in this Certificate. Coinsurance counts toward your Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, you will not be responsible for Coinsurance for the remainder of the Calendar Year.

NOTE: A Rider attached to this Certificate may amend Coinsurance.

Coinsurance for In-Network Benefits

- Your Coinsurance is 20 percent (20%) of the Approved Amount for the Covered Services listed below.
  - Inpatient Hospital services; including mental health and substance use disorder
  - Organ and tissue transplants
  - Outpatient Hospital services
  - Diagnostic tests and x-rays including radiation therapy
  - Sterilization of male reproductive organs
  - Skilled nursing
  - Reconstructive surgery
  - Cancer drug therapy administration

- Your Coinsurance is 50 percent (50%) of the Approved Amount after the In-Network Deductible is satisfied for the services listed below.
  - Infertility
  - Reduction mammoplasty and male mastectomy
  - TMJ treatment
  - Orthognathic surgery
  - Weight reduction procedures

Coinsurance for Out-of-Network Benefits

- Your Coinsurance is 40 percent (40%) of the Approved Amount for the majority of the Covered Services listed in this chapter. Please reference the specific Covered Service to confirm the applicable Coinsurance.
- Your Coinsurance is 50% of the Approved Amount after the Out-of-Network Deductible is satisfied for the services listed below:

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– Allergy testing and treatment

– Reduction mammoplasty and male mastectomy

– TMJ treatment

– Orthognathic surgery

Cost Sharing – Deductible, Coinsurance, and Copay Calculation

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

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you pay for Covered Services under this Certificate and any attached Riders per Calendar Year. The Out-of-Pocket Maximum includes your BCN medical and BCN Prescription Drug Deductible, Copay and Coinsurance. The federal government sets the maximum amount annually.

If you use both In-Network and Out-of-Network Benefits, separate Out-of-Pocket Maximums apply. The Out-of-Pocket Maximum for In-Network and Out-of-Network Benefits is not combined to satisfy the Out-of-Pocket Maximum limit.

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

- Any Premium or contributions paid toward the Premium does 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.

Out-of-Pocket Maximum renews each Calendar Year and does not carry over to the next Calendar Year.

NOTE: The Out-of-Pocket Maximum amount is reflected in 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 examples of Covered Services that have a Benefit Maximum include but are not limited to:

- Medical rehabilitation and habilitative services
- Spinal manipulation
- Skilled Nursing services

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8.3 Balance Bills

In-Network Benefits: You are not responsible for the difference between the Participating Provider's charge and the BCN Approved Amount.

Out-of-Network Benefits: You may be responsible for amounts charged by a Non-Participating Provider that exceed the Approved Amount. (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference).

8.4 Medical Professional Physician Services

We cover:

A) Physician Services at an office site, hospital location or Online Visit

- Primary Care Physician (PCP)
- OB/GYN
- Specialist physician
- Online Visit

  We cover Online Visits by a professional provider, or an online vendor selected by BCN to:

  – Diagnose a condition
  – Make treatment and consultation recommendations
  – Write a prescription, if appropriate
  – Provide other medical or health treatment

  The Online Visit must allow the Member to interact with a professional provider or an Online Visit vendor in real time. Treatment and consultation recommendation made Online, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

  NOTE: Not all services delivered virtually are considered an Online Visit, but maybe considered Telemedicine. Telemedicine services will be subject to the applicable Cost Share associated with the service provided.

  Online Visit exclusions include but are not limited to:

  – Reporting of normal test results
  – Provision of educational materials
  – Handling of administration issues, such as registration, scheduling of appointments, or updating billing information

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B) ***Eye Care*** – treatment of medical conditions and diseases of the eye – may require Preauthorization by BCN

OFFICE VISIT COST SHARING	
In-Network Benefits	**Out-of-Network Benefits**
$10 Copay for each Primary Care Physician office visit $10 Copay per Online visit when performed by the PCP, specialist physician or a BCN online vendor $25 Copay for Specialist visit Applies toward the In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum
NOTE: Non-preventive diagnostic, therapeutic and surgical procedures performed in the office are subject to the applicable Deductible, Copayment and Coinsurance. See Preventive and Early Detection Services section for more information about office visits.	

C) ***Maternity Care*** - **prenatal and postnatal office visits when provided by your Primary Care Physician, OB/GYN or Certified Nurse Midwife**

MATERNITY CARE COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
Routine prenatal and postnatal visits are covered in full. $10 Copay per office visit Applies toward the In-Network Out-of-Pocket Maximum We cover maternity education when provided by your PCP, Participating OB/GYN or Participating Certified Nurse Midwife.	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum
NOTE: The office visit Copayment does not apply to routine prenatal and postnatal visits. The Copayment does apply to non-routine (non-preventive) high risk prenatal and postnatal visits.	

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D) ***Home Visits*** by a physician in your home or temporary residence. For home healthcare Services other than physician visit, please see the Home Healthcare Services section in this chapter.

HOME VISITS COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
Covered in full after In-Network Deductible	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum

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

INPATIENT PROFESSIONAL SERVICES COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward the In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum

F) ***Allergy Care*** - Allergy testing, evaluation, serum and injection of allergy serum

ALLERGY CARE COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
Covered in full Office visit Copayment may apply per Member per visit Applies toward the In-Network Out-of-Pocket Maximum	50% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum

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G) *Chiropractic Services and Osteopathic Manipulative Therapy* when provided by a BCN Participating Chiropractor or Osteopathic Physician

CHIROPRACTIC SERVICES COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
Office visits are covered the same as Specialist 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 Copay 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.	Not covered

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. The 30-visit limit is combined whether the manipulations are performed by a chiropractor or an osteopathic provider.

Visits for mechanical traction are applied toward your Benefit Maximum for physical, speech, and occupational therapy services. The therapies (mechanical traction or physical, speech, and occupational therapy) are the combined Benefit defined under Outpatient Therapy section.

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H) Medical Services at a Pharmacy

Covered services performed by a pharmacist, which may include certain medical evaluations and testing, when performed at a BCN affiliated immunization pharmacy. When services are received at a non-immunization affiliated pharmacy, the services are not covered.

MEDICAL SERVICES AT A PHARMACY COST-SHARING	
In-Network Benefits	**Out-of-Network Benefits**
$10 Copay for each medical evaluation by a pharmacist. Evaluations are covered the same as the Primary Care Physician office visits.	Not Covered
NOTE: An affiliated immunization pharmacy can be found through the Find Care option through your BCBSM secured member account.	

8.5 Continuity of Care for Professional and Facility Services

Continuity of Care for Existing Members

When a contract terminates between BCN and a Participating Provider (including your Primary Care Physician) who is actively treating you for conditions under the circumstances listed below and as required by law, the disaffiliated provider (physician or Facility) may continue treating you.

BCN will notify you of the provider's termination. If you qualify for Continuity of Care, you may continue receiving treatment with that provider for up to 90 days. During that Continuity of Care, your plan In-Network Cost Share will apply.

Provider Requirements

The Continuity of Care provisions apply only when your provider (physician or Facility):

- Agrees you qualify as a continuing care member
  - If the provider agrees you are a continuing care member, the provider must, to the extent required by applicable law, accept the BCN Approved Amount as payment in full for the services provided as if the provider's contract had not changed
- Continues to meet BCN's quality standards
- Continues to adhere to BCN medical and quality management policies and procedures
- Provides care for 90 days of continued coverage or until you are no longer a continuing care member whichever occurs first. The 90 days may be extended if agreed by BCN and the provider

NOTE: Emergency room services will continue to be covered as required by law; see Surprise Billing section for additional information.

Continuing Care Member Requirements

You qualify as a continuing care member if you are:

- Undergoing a course of treatment for a "serious and complex condition", defined as one of the following:

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    - An acute illness – a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
    - A chronic illness or condition - a condition that is life-threatening, degenerative, potentially disabling, or congenital; and that requires specialized medical care over a prolonged period of time.
- Undergoing a course of inpatient care
- Scheduled to undergo nonelective surgery, including receipt of postoperative care for that surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Determined to be terminally ill (defined as "a medical prognosis that the individual's life expectancy is six months or less") and is receiving treatment for this illness

Coverage
If you qualify as a continuing care member, , BCN will continue to provide coverage at the In-Network Benefit for the Covered Services when provided for an ongoing course of treatment as detailed above for 90 days or you are no longer a continuing care member whichever is shorter. For additional Covered Services to be paid at the In-Network Benefit Level, your Participating Primary Care Physician must provide or coordinate all such services.

If the above conditions are not met, Covered Services will be paid at the Out-of-Network Benefit level.

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. For the services to be paid by BCN at the In-Network benefit level, at the time of enrollment you must select a Primary Care Physician who will coordinate your care with the Non-Participating Provider.

If you qualify as a continuing care member, BCN will continue to provide coverage for the Covered Services at the In-Network benefit level when provided for an ongoing course of treatment as described below for 90 days or you are no longer a continuing care member whichever is shorter. The 90 days may be extended if agreed by BCN and the provider.

Continuing Care Member Requirements
You qualify as a continuing care member if you are:

- Undergoing a course of treatment for a "serious and complex condition", defined as one of the following:
    - An acute illness – a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
    - A chronic illness or condition - a condition that is life-threatening, degenerative, potentially disabling, or congenital; and that requires specialized medical care over a prolonged period of time.
- Undergoing a course of inpatient care

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- Scheduled to undergo nonelective surgery, including receipt of postoperative care for that surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Determined to be terminally ill (defined as "a medical prognosis that the individual's life expectancy is six months or less") and is receiving treatment for this illness

Coverage
Coverage will be provided for Covered Services under the In-Network Benefits for an ongoing course of treatment, subject to the Criteria detailed above. For additional Covered Services to be paid at the In-Network Benefit Level, your Participating Primary Care Physician must provide or coordinate all such services.

If the above conditions are not met, Covered Services will be paid at the Out-of-Network Benefit level.

8.6 Preventive and Early Detection Services

We cover Preventive and Early Detection Services as defined in the federal Patient Protection and Affordable Care Act ("PPACA"). These services must be provided or coordinated by your Primary Care Physician. The services are modified by the federal government from time to time. Preventive Services include but are not limited to the following.

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

Health screenings include but are not limited to:

- Obesity
- Vision and hearing (See Section 9 for exclusions and limitations.);
- Glaucoma
- EKG
- Type 2 diabetes mellitus
- Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

B) Women's health and well-being

We follow PPACA guidelines consistent with the HRSA-Supported Women's Preventive Services Guidelines for the following services:

GYNECOLOGICAL (well woman) examinations, including routine pap smear
Additional cervical cancer screening services may be required to address findings from the initial screening. These services are covered as preventive if received within 12 months of a routine pap smear, but not more than one per year.

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

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SCREENING MAMMOGRAPHY – One per Member per Calendar Year to screen for breast cancer

Additional breast cancer screening services, such as an ultrasound, may be required to address findings from the initial screening mammography. Each of the additional services are covered as preventive if received within 12 months of a screening mammography but not more than one per year.

In-Network Benefits	Out-of-Network Benefits
Covered in full	40% Coinsurance of the Approved Amount after Out-of-Network Deductible

SCREENING FOR OSTEOPOROSIS TO PREVENT FRACTURES

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

SCREENING FOR SEXUALLY TRANSMITTED DISEASES; HIV counseling and screening

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

MATERNITY COUNSELING for the promotion and support of breast-feeding, prenatal vitamin counseling, and alternative fertility awareness methods

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

MATERNITY SCREENING for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit); Rh(D) incompatibility screening; and gestational diabetes

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

ROUTINE PRENATAL AND POSTNATAL OFFICE VISITS

In-Network Benefits	Out-of-Network Benefits
Covered in full	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward the Out-of-Network Out-of-Pocket Maximum

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STERILIZATION PROCEDURES for Members with female reproductive organs such as tubal ligation and related charges associated with the procedures (anesthesia, labs, etc.)

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

BREAST PUMP AND ASSOCIATED SUPPLIES needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. (See Durable Medical Equipment section for limitations and exclusions)

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

CONTRACEPTIVE COUNSELING AND METHODS including measurement, fittings, insertion, removal, administration and management of contraceptive care for Members as required by PPACA

In-Network Benefits	Out-of-Network Benefits
Covered in full FDA-approved contraceptives methods include: – Contraceptive devices and appliances; such as intrauterine devices (IUDs) Implantable and injected drugs such as Depo-Provera and diaphragms – Contraceptive mobile app; one annual membership (12 consecutive months) per Member – When you purchase a yearly subscription for an FDA-approved contraceptive mobile app, log into your Member account at https://www.bcbsm.com to find and fill out a reimbursement form. Submit the form along with your receipt for reimbursement. BCN will reimburse you up to charge for your yearly subscription.	Not covered

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SCREENING AND COUNSELING FOR INTIMATE PARTNER AND DOMESTIC VIOLENCE

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

GENETIC COUNSELING and BRCA testing if appropriate for Members whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

C) *Newborn screenings and well child assessments and examinations*

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

D) *Immunizations* (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered
NOTE: Flu shots and travel vaccines are covered in full In-Network and Out-of-Network.	

E) *Nutritional counseling* including Diabetes Self-Management, morbid obesity, and diet behavioral counseling

Morbid Obesity Weight Management – Dietician services billed by a physician or other provider recognized by BCN

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

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 Physician 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

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F) ***Routine cancer screenings*** including but not limited to colonoscopy, flexible sigmoidoscopy, and prostate (PSA/DRE) screenings (For the purposes of this Certificate "Routine" means non-urgent, non- emergent, non-symptomatic medical care provided for the purpose of disease prevention.)

In-Network Benefits	Out-of-Network Benefits
Covered in full	Colonoscopy and mammography - 40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum *All other routine cancer screenings* - Not Covered

G) ***Depression screening, substance use disorder/chemical dependency*** screening when performed by your Primary Care Physician

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

H) ***Aspirin therapy*** counseling for the prevention of cardiovascular disease

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

I) ***Tobacco use*** and tobacco caused disease counseling

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not covered

NOTE: Cost Sharing will apply to non-routine diagnostic procedures. If this Certificate is amended by Deductible, Copay or Coinsurance Riders, the attached Riders will take precedence over the Certificate for non-preventive services.

Any Member Cost Sharing for office visits will still apply with the following restrictions.

- If a recommended Preventive or Early Detection Service is billed separately from the office visit, then you will be responsible for the office visit Cost Sharing. There will be no Cost Sharing for the Preventive or Early Detection Service;
- If a recommended Preventive 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 or Early Detection Service, you will have no Cost Sharing for the office visit.
- If a recommended Preventive 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 or Early Detection Service, you will be responsible for payment of any Cost Sharing for the office visit.

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NOTE: To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to the following website: https:www.healthcare.gov/coverage/preventive-care-benefits/. You may also contact BCN Customer Service.

8.7 Inpatient Hospital (Facility) Services

We cover the following Inpatient Hospital (Facility) Services, when determined to be Medically Necessary and Preauthorized by BCN. Services include but are not limited to the following:

- Room and board, general nursing Services and special diets
- Operating and other surgical treatment rooms, delivery room and special care units
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, radiation therapy, inhalation therapy and dialysis
- Physical, speech and occupational therapy
- Long-term Acute Care
- Other Inpatient Services and supplies when Medically Necessary
- Maternity care and all related services when provided by the attending physician or Certified Nurse Midwife. The Certified Nurse Midwife must be overseen by an OB/GYN.

  Under federal law, the gestational parent is 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 Preauthorization is not required for the minimum hospital stay.

  NOTE: Maternity Care includes coverage of the Member's newborn only during the 48 or 96 hours when the newborn has not been added to a BCN contract. These services include:

  - Newborn examination given by a physician other than the anesthesiologist or the Member's attending physician
  - Routine Care during the newborn's eligible hospital stay
  - Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities during the newborn's eligible hospital stay

- Newborn care

  Under federal law, the newborn child is 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

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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 Preauthorization is not required for the minimum hospital stay.

Newborn care includes:

- Newborn examination given by a physician other than the anesthesiologist or the Member's attending physician
- Routine Care during the newborn's eligible hospital stay

NOTE: If the newborn is not covered under any other healthcare benefit plan on their date of birth, they may qualify for coverage under the Member's maternity care benefit for the period of 48 or 96 hours.

Certain Inpatient Hospital Services have separate requirements. Your Cost-Sharing is different. (See, for example, Coverage for reduction mammoplasty, TMJ treatment, orthognathic surgery and weight reduction procedures or any attached Riders.)

See section 8.4 for Inpatient Professional Services for Cost Sharing.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

8.8 Outpatient Services

We cover Outpatient Services when Medically Necessary and Preauthorized by your treating physician and BCN.

You receive Outpatient Services in these places:

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

Outpatient Services include but are not limited to:

- Facility and professional (physician) Services
- Surgical treatment

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- 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 Medical Professional Physician Services section
- Professional Services-see Medical Professional Physician Services section
- Durable medical equipment and supplies-see Durable Medical Equipment section
- Diabetic equipment and supplies-see Diabetic Supplies and Equipment section
- Prosthetic and orthotic equipment and supplies-see Prosthetic and Orthotics section
- Other Medically Necessary Outpatient Services and supplies

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

Cost Sharing - Facility and Professional Services

In-Network Benefits	Out-of-Network Benefits
Outpatient diagnostic laboratory and pathology tests Covered in full Deductible does not apply ***All other services*** 20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	*Outpatient diagnostic laboratory and pathology tests* Covered in full Deductible does not apply ***All other services*** 40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum
NOTE: Out-of-Network Benefits for preventive health procedures are not covered except for certain services. See Preventive and Early Detection Services section.	

High Technology Radiology Services such as MRI, MRA, CAT, PET when Medically Necessary and Preauthorized by BCN

In-Network Benefits	Out-of-Network Benefits
$150 Copayment Applies toward the In-Network Out-of-Pocket Maximum **NOTE:** One Copayment applies per day per provider for any combination of high technology radiology services.	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

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8.9 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 below

- **Medical Emergency** - Whether a condition is a "Medical Emergency" does not depend on a particular diagnosis. Instead, it is based on the sudden onset of a serious medical condition resulting from injury, sickness or behavioral health condition 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 Member, serious impairment to bodily function, or serious dysfunction of any bodily organ or part

- **Stabilization** - the point at which, it is reasonably probable that no material deterioration of a condition is likely 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 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 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 on your behalf to notify your Primary Care Physician or BCN within 24 hours, or as soon as medically reasonable. Admission to the Hospital after a Medical Emergency has been Stabilized requires authorization by BCN. However, Prior Authorization is not required for you to obtain Emergency Services.

Emergency Services include professional and related ancillary services and Emergency Services provided in an urgent care center, Hospital emergency room or independent freestanding emergency departments, or in your home if available through a BCN vendor contracted to coordinate care in the home. Emergency Services are covered regardless of whether the provider or Facility is participating.

In participating Hospitals and independent free standing emergency departments, Emergency Services are no longer payable as Emergency Services at the point of the Member's Stabilization as defined above. In Non-Participating Hospitals and independent free standing emergency departments, services rendered after the Member is Stabilized will continue to be Emergency

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Services until the Member receives and signs a notice and consent form as required under the No Surprises Act.

If you receive Emergency Services rendered by a Non-Participating Provider in any hospital or freestanding emergency department, administrative requirements will be the same, regardless of the facility's participating status, and payment and Cost Sharing will be based on Michigan law or the federal No Surprises Act. Any amount paid for Emergency Services will apply to your plan In-Network Deductible and In-Network Out-of-Pocket Maximum.

NOTE: Observation stay resulting from Emergency Services is subject to Emergency room Cost Sharing defined below.

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 BCN. This applies even if the Hospital emergency staff or physician instructed you to return for follow-up.

Emergency Services In-Network and Out-of-Network
$150 Copay for Emergency Services provided in a Hospital emergency room Applies toward In-Network Out-of-Pocket Maximum

If you are admitted as an Inpatient because of the Emergency, the Emergency Copayment is waived. The Inpatient Hospital benefit as described in this chapter and attached Riders will apply.

If you are admitted for Observation Care, rather than being formally admitted as an Inpatient in the Hospital, services and treatment provided while you are considered to be admitted for Observation Care are subject to the Emergency Services Copayment guidelines above.

Admission to 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, you may be required to sign a notice and consent form by the Non-Participating Hospital to continue receiving services. If you sign this form, all related non-Emergency Covered Services will be covered at the Out-of-Network Benefit level from the date of when the form is signed.

Out-of-Area and Non-Participating Provider Coverage

You are covered when traveling within or outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above. (See Section 9 and the attached Inter-Plan Programs addendum for additional information.)

When Services are rendered by a Non-Participating Provider, we pay a rate based on the requirements of state and federal laws.

You are responsible for any Cost Sharing required under this Certificate or amended by a Rider. The rate we pay for Emergency Services may be less than the bill; you will not be required

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to pay the difference between what the Provider charges and what we pay. See Surprise Billing section for more information.

Urgent Care Services In-Network and Out-of-Network Cost Sharing
$50 Copay for Emergency services in an Urgent Care Center Applies toward In-Network Out-of-Pocket Maximum

8.10 Ambulance

An ambulance is a ground or air service that transports an injured or sick Member to a covered destination.

For ground ambulance, a covered destination may include:

- A hospital
- A Member's home
- Other facilities

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

We will pay for a Member to be taken to the nearest destination capable of providing necessary care to treat the Member's condition.

NOTE: Transfer of the Member between covered destinations must be prescribed by the attending physician and Preauthorized by BCN.

In every case, the following ambulance criteria must be met:

- The service must be Medically Necessary. Any other means of transport would endanger the Member's health or life
- Coverage only includes the transportation of the Member and whatever care is required during transport. Other services that might be billed with the transportation is not covered
- The service must be provided in a licensed ground or air ambulance that is part of a licensed ambulance operation

Coverage also includes when:

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

Non-emergency ground ambulance services are covered when Preauthorized by your treating physician and BCN

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Air ambulance

Air Ambulance services must also meet these requirements:

- No other means of transport are available
- The Member's condition requires transportation by air ambulance rather than ground ambulance
- An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.
- Non-Emergent air ambulance services must be approved before they occur. If they are not Preauthorized, they will be considered a noncovered benefit and you may have to pay the entire cost. It is important to make sure your provider gets approval before you receive services.
- The Member is transported to the nearest facility capable of treating the Member's condition.

NOTE: Air ambulance transportation that does not meet the requirements described above is eligible for review and possible approval by BCN. We may recommend coverage for transportation that positively impacts clinical outcomes, but not for the convenience of the Member or the family.

In-Network and Out-of-Network
$50 Copay per ground and air ambulance transport services Applies toward In-Network Out-of-Pocket Maximum

Exclusions include but are not limited to

- Transportation 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.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the Member's condition does not require air ambulance transport
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.

8.11 Reproductive Care and Family Planning

We cover:

- Non-Elective Abortion
- Abortion Genetic testing
- Voluntary sterilization
- Infertility
- Fertility Preservation

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A) Non-Elective Abortion

We cover Non-Elective Abortion services **only** when meeting federally funded program guidelines, no matter the location. These guidelines are detailed below:

- In the case of a physical disorder, physical injury, or physical illness, including life-endangering physical condition caused by or arising from the pregnancy itself, that would, in the treating physician's opinion, place the Member in danger of death unless an abortion is performed.
- In the case of rape or incest when the abortion is legal in the location where the service is rendered

NOTE: Abortion does not include:

- Prescription drugs or devices intended to prevent a pregnancy
- Treatment upon a pregnant Member who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy
- Treatment to preserve the life and health of the child after birth

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Your In-Network Inpatient and Outpatient benefit applies to Non-Elective Abortion procedure including office consultations	Your Out-of-Network Inpatient and Outpatient benefit applies to Non-Elective Abortion procedure including office consultations

Exclusions include but are not limited to

- Any service related to Elective Abortion (unless covered by an Elective Abortion Rider)
- Cases not identified above
- Abortions otherwise prohibited by law

B) 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: In-Network genetic counseling and BRCA testing if appropriate for biological 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)

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
$10 Copayment per Primary Care Physician office visit $25 Copayment for Specialist office visit	40% Coinsurance of the Approved Amount after Out-of-Network Deductible

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Applies toward In-Network Out-of-Pocket Maximum	Applies toward Out-of-Network Out-of-Pocket Maximum

Exclusions include, but are not limited to
Genetic testing and counseling for non-Members

C) Voluntary Sterilization
We cover Inpatient, Outpatient, and office based sterilization services.

Sterilization of Female Reproductive Organs - Covered in full In-Network as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services

Cost Sharing- Sterilization of Male Reproductive Organs

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible when Preauthorized by BCN Applies toward In-Network Out-of-Pocket Maximum	Not covered

Exclusions include, but are not limited to
Reversal of surgical sterilization

D) Infertility
We cover diagnosis, counseling, select drugs, and treatment of Infertility when Medically Necessary and Preauthorized by BCN except as stated below and in Section 9. Following the initial sequence of diagnostic work-up, additional work-ups are covered only when Preauthorized by BCN.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible applies for all fees associated with infertility diagnostic work-up procedures, treatment and all facility professional and related services, including select prescription drugs approved by BCN Applies toward In-Network Out-of-Pocket Maximum	Not covered

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Exclusions include but are not limited to

- Harvesting
- Storage or manipulation of eggs and sperm

  Note: manipulation of sperm such as sperm washing is covered when associated with artificial insemination for Members with infertility diagnosis.
- 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
- In-vitro fertilization (IVF) procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related services
- Artificial insemination (except for treatment of infertility)
- All services 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)

E) Fertility Preservation

We cover preservation of fertility only for Members diagnosed with cancer. Preservation of fertility may be considered when the cancer treatment will affect the Member's fertility.

We cover the following procedures for fertility preservation:

- Collection of mature eggs and sperm
- Cryopreservation of embryos, mature eggs and sperm
- Storage of embryos, mature eggs and sperm for up to two years
- Thawing of embryos, mature eggs and sperm within two years of the procurement
- Culture of eggs
- Ovarian transposition
- Embryo transfer to Member within two years from cryopreservation

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Your In-Network Inpatient and Outpatient Cost Share applies to fertility preservation procedures including office consultations, diagnostic and surgical services.	Your Out-of-Network Inpatient and Outpatient Cost Share applies to fertility preservation procedures including office consultations, diagnostic and surgical services.

Exclusions include but are not limited to:

- Storage of sperm, eggs or embryos for longer than two years
- Co-culture of embryo(s)
- Post-menopausal members
- Members who have undergone elective sterilization (vasectomy, tubal sterilization), with or without reversal

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8.12 Skilled Nursing Facility

We cover services for recovery from surgery, disease or injury, whether provided In-Network or Out-of-Network. Skilled Nursing Facility must be Medically Necessary and Preauthorized by BCN.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum
Benefit Maximum Up to a total cumulative Benefit Maximum (In-Network Benefit and Out-of-Network) of 45 days per Calendar Year	

Exclusions from In-Network and Out-of-Network Benefits include but are not limited to

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

8.13 Hospice Care

Hospice care is an alternative form of medical care for terminally ill 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 licensed hospice facility, hospital or Skilled Nursing Facility is covered. We also cover hospice care in the home.

We cover the following Services:

- 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.

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Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Covered in full after In-Network Deductible	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

Exclusions from In-Network and Out-of-Network Benefits 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

8.14 Home Healthcare Services

Under this section, we cover care and services provided in a Member's home only when provided by a home health agency.

Home Healthcare provides an alternative to long-term hospital care by offering coverage for care and services in the Member's home.

Home healthcare must be:

- Medically Necessary
- Provided by a Home Healthcare agency
- Provided by professionals employed by the agency and who participate with the agency

We cover the following Services:

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home healthcare agency
- Intermittent physical, speech or occupational therapy

  NOTE: Outpatient therapy limits as defined in Outpatient Therapy Service section do not apply.
- Other healthcare services approved by BCN when performed in the Member's home

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Covered in full after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

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Exclusions from In-Network and Out-of-Network Benefits include but are not limited to

- Housekeeping services
- Custodial Care (See Section 9)

8.15 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 home infusion therapy services when Medically Necessary and Preauthorized by BCN.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Covered in full after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

8.16 Behavioral Health Services (Mental Healthcare and Substance Use Disorder)

A. Mental Healthcare

We cover evaluation, consultation and treatment necessary to determine a diagnosis and treatment for mental health conditions that are in accordance with generally accepted standards of practice. Non-Emergency Mental Health services may require Preauthorization by BCN. For a list of services requiring Preauthorization, contact Customer Service or visit https://bcbsm.com/priorauth. (Mental Health Emergency Services are covered – see Emergency and Urgent Care section.)

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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.

Residential Mental Health Treatment is a state-licensed facility that allows for 24-hour domiciliary care and supervision for safety. The Facility provides continuous treatment by or under the supervision of a qualified professional provider 24/7 with a response time to the facility in case of emergency within 60 minutes.

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 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
- Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program").
- The treatment is managed by a multidisciplinary treatment team and reviewed regularly with the Member and team at least weekly.

Partial Hospitalization Mental Health is a comprehensive acute care program that consists of a minimum of 4 hours per day, at least 3 days per week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluations and other services as needed.

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

Outpatient Mental Health services include individual, conjoint, family or group psychotherapy, psychiatric evaluation, counseling, medical testing and crisis intervention.

Coverage

Mental healthcare is covered in either an Inpatient or Outpatient setting. To obtain services, call the mental health treatment number shown on the back of your BCN ID card. They are available 24 hours a day, 7 days a week.

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Cost Sharing

Inpatient Mental Health/Residential Mental Health/Partial Hospitalization

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

Outpatient Mental Health/Intensive Outpatient Mental Health

In-Network Benefits	Out-of-Network Benefits
$10 Copay per visit, no matter the location, including online visits Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum
NOTE: Diagnostic testing, injections, therapeutic treatment and medical services are subject to the medical Outpatient Services Cost Sharing.	

NOTE: See Section 9 for exclusions and limitations.

B. Substance Use Disorder Services

Substance Use Disorder treatment means treatment for physiological or psychological dependence on or abuse of alcohol, drugs or other substances. Diagnosis and treatment may include medication therapy, psychotherapy, counseling, detoxification services, medical testing, diagnostic evaluation, and other services as needed.

Non-Emergency Substance Use Disorder treatments may require Preauthorization by BCN. For a list of services requiring Preauthorization, contact Customer Service or visit https://bcbsm.com/priorauth. (Substance Use Disorder Emergency Services are covered – see Emergency and Urgent Care services section.)

Medical Inpatient services required during a period of substance use disorder admission must be authorized separately by your Primary Care Physician and BCN.

Definitions

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

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- **Residential Substance Use Disorder Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical Hospitalization. Residential services may include 24-hour professional supervision. Services may include counseling, Detox, medical testing, diagnostic and medication evaluation and other services as needed. Residential Substance Use Disorder Treatment is sometimes referred to as Intermediate Care. Residential substance use disorder is not considered inpatient acute medical /surgical care in a hospital.

- **Intermediate Care** refers to substance use disorder services that have a residential (overnight) component. Intermediate Care includes Detox, domiciliary partial and residential (including "inpatient") services.

- **Partial Hospitalization** is a comprehensive acute-care program that consists of a minimum of 4 hours per day, 3 days per week. Partial Hospitalization treatment may include but is not necessarily limited to psychiatric evaluation and management, counseling, medical testing, diagnostic and medication evaluation, and other services as needed.

- **Domiciliary Partial** refers to Partial Hospitalization combined with an unsupervised overnight stay component.

- **Domiciliary Intensive Outpatient Substance Use Disorder Treatment** refers to Intensive Outpatient combined with an unsupervised overnight stay component.

- **Intensive Outpatient Substance Use Disorder Treatment** means treatment that is provided on an Outpatient basis consisting of a minimum of 3 hours per day, 3 days per week and might include, but are not limited to, individual, group and family counseling, medical testing, diagnostic and medication evaluation and other services as needed.

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

Coverage

We cover Substance Use Disorder Services including counseling, medical testing, diagnostic evaluation and detoxification in a variety of settings. To obtain services, call the Substance Use Disorder Treatment number shown on the back of your BCN ID card. They are available 24 hours a day 7 days a week.

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Cost Sharing

Detox/Residential/Intermediate Care/Partial Hospitalization/Partial Domiciliary Substance Use Disorder

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder

In-Network Benefits	Out-of-Network Benefits
$10 Copay per visit, no matter the location Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum
NOTE: Diagnostic testing, injections, therapeutic treatment and medical services are subject to the medical Outpatient Services Cost Sharing.	

NOTE: See Section 9 for exclusions and limitations

8.17 Autism Spectrum Disorders

Definitions

Applied Behavior 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 or Hospital-based, interdisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the ASD. An interdisciplinary evaluation such as that available at an AAEC is necessary to obtain Preauthorization for ABA.

Autism Spectrum Disorders ("ASD") means a developmental disability caused by differences in the brain. Autism Spectrum Disorder (ASD) is characterized by impaired social function, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests. The treatment of ASD may be behavior modification.

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Autism Spectrum Disorder Services are services that require a prior authorization for assessment, reassessment and supervision of applied behavior analysis (ABA), line therapy, skills training, and caregiver training.

Evaluation must include a review of the Member's clinical history and examination of the Member. An evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening as needed.

Line Therapy means tutoring or other activities performed one-on-one with a person diagnosed with ASD.

Benefits

Services for the diagnosis and treatment of ASD are covered when provided by a licensed provider and Preauthorized by BCN.

We cover:

- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's ASD

- Therapeutic care including:
  - Occupational therapy, speech therapy and physical therapy
  - Autism Spectrum Disorder Services (including ABA) when performed by a licensed behavior analyst or other providers acting within their scope of practice
  - Outpatient mental health therapy
  - Genetic testing
  - Nutritional therapy

- Services and treatment must be Medically Necessary, Preauthorized and deemed safe and effective by BCN

Coverage

ABA or Line Therapy In-Network and Out-of-Network services are subject to the In-Network and Out-of-Network outpatient behavioral health Cost Share as defined in this Certificate and applicable riders. If a Rider is added specific to Applied Behavior Analysis to your plan, the Cost Share within the Rider will apply, the outpatient behavioral health Cost Share will not apply in this instance.

Behavioral health services are subject to the behavioral health Cost Share as defined in this Certificate and applicable Riders

Outpatient therapy services are subject to the applicable In-Network or Out-of-Network Specialist Cost Sharing as defined in this Certificate and Riders associated with your plan.

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Services performed to treat ASD will not count toward Benefit Maximums in your Coverage, including but not limited to, visit or treatment limits imposed on physical therapy, speech-therapy or occupational therapy.

Benefit Limitations

Coverage is available subject to the following requirements:

- **Preauthorization** – In-Network and Out-of-Network services must be approved for payment during BCN's Preauthorization process. If Preauthorization is not obtained, rendered services will not be covered. The Member may be held responsible for payment for those services. Once the initial Preauthorization expires, a request for continued services will be authorized contingent on the Member demonstrating meaningful improvement and therapeutic progress.

- **Providers** – To receive lower out of pocket costs, In-Network services to treat ASD must be performed by a BCN Participating Provider. If services are rendered by an Out-of-Network provider, you are responsible for higher out of pocket costs and any amount charged that exceeds the BCN Approved Amount

- **Required Evaluation for ABA** – In order to receive Preauthorization, the Member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist. This interdisciplinary evaluation can be performed at an approved AAEC. Other Preauthorization requirements may also apply.

Exclusions include but are not limited to

- Any treatment that is not specifically covered in the Autism Spectrum Disorders section and that is considered experimental/investigational by, or is otherwise not approved by BCN in meeting medical criteria and established guidelines
- Treatment for conditions not covered under BCN medical policy

8.18 Outpatient Therapy Services

Outpatient therapy and rehabilitative medicine services are 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 – including but not limited to cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic and Osteopathic mechanical traction
- Biofeedback for treatment of select medical diagnoses when Medically/Clinically Necessary as determined according to BCN medical policies

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We cover

Short-term Outpatient Therapy Services when meeting the following criteria:

- Preauthorized by BCN as Medically Necessary
- Treatment for recovery from surgery, disease or injury
- 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 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 – In and Out-of-Network

- 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 Member per Calendar Year

Habilitative – In and Out-of-Network

- 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.

NOTE: Outpatient Therapy Services provided In-Network and Out-of-Network are cumulative. For example, use of a Benefit provided In-Network will reduce the Benefit available In-Network and Out-of-Network. For rehabilitative and habilitative visits, when two or more therapies are received on the same treatment day, each type of therapy counts as one visit. For example, if you have physical and occupational therapy on the same day it counts as two visits against your limit.

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Cost Sharing

In-Network Benefits	Out-of-Network Benefits
$25 Copay per visit Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

General Exclusions include but are not limited to

- Cognitive rehab and retraining (neurological training or retraining)
- Services that are provided by a federal or state agency or local political subdivision, including school districts, when the Member is not liable for the costs
- Vocational rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return-to-work programs
- Treatment during school vacations when also provided by the school system or other public agency
- Craniosacral therapy
- Prolotherapy
- Rehabilitation services obtained from non-Health Professionals, including massage therapists
- Strength training and exercise programs
- Sensory integration therapy, except for Autism Spectrum Disorder

Additional Exclusions for Speech Therapy include but are not limited to

- Sensory, behavioral, cognitive or attention deficit/hyperactivity (ADHD) disorders;
- Treatment of stuttering or stammering when it is determined that the condition is self-correcting and not severe
- 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, or singing. Voice therapy is, however, covered in the presence of vocal cord nodules, polyps or vocal cord paralysis.
- Summer speech therapy programs when also provided by the school system or other public agency

8.19 Durable Medical Equipment

Durable Medical Equipment (DME) must be:

- Medically Necessary
- Used primarily for medical purposes
- Prescribed by the treating physician
- Intended for repeated use
- Useful primarily because of illness, injury or congenital defect

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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 Medically Necessary and Preauthorized by BCN. Items are payable when received from an In-Network DME Participating Provider or a Participating facility upon discharge.

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

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not Covered

NOTE: The following items are covered in full when Preauthorized and obtained from a DME Participating Provider as mandated by the Affordable Care Act preventive services:

- Breast pump and associated supplies needed to support breast-feeding (See Preventive and Early Diagnosis section).
- Blood pressure monitor when Member has elevated blood pressure reading regardless of hypertension diagnosis

Limitations and Exclusions – In-Network Benefits

Limitations include but are not limited to

- The equipment must be considered DME under your Coverage
- Appropriate for home use
- Obtained from a BCN Participating Provider
- Prescribed by your Primary Care Physician or a Professional 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 is covered 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 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 your option. You are

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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 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, or damage or damage that cannot be repaired
- Assistive technology and adaptive equipment such as and 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
- Any late fees or purchase fees if the rental equipment is not returned within the stipulated period of time

8.20 Diabetic Supplies and Equipment

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

Diabetic Supplies and Equipment must be:

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

We cover the following:

- 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

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- Medical supplies required for the use of an insulin pump
- Diabetic shoes and inserts
- Continuous glucose monitors
  NOTE: Continuous glucose monitors (CGMs) and related supplies are covered only when obtained from the BCN designated exclusive vendor. CGMs and related supplies are not covered when supplied through any In-Network Pharmacy or durable medical equipment (DME) supplier that is not the BCN designated exclusive vendor. If your CGM and related supplies are not received from the BCN designated exclusive vendor, you may be responsible for the total cost.

Diabetic supplies and equipment are limited to basic equipment. Special features must meet Medical Necessity criteria and may require Prior Authorization by BCN, and obtained from a BCN Participating Provider. 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 is 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.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not Covered

NOTE: You may also obtain certain diabetic supplies and equipment through a BCN Participating Pharmacy as defined on your Drug List. Applicable prescription drug Cost Sharing will apply.

Exclusions include but are not limited to

- Replacement due to loss, theft 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

8.21 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 Prosthetic Devices** - Devices such as an artificial leg, artificial arm or the initial set

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

- **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, or 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

Basic Medically Necessary Prosthetics and Orthotics are covered In-Network when Preauthorized by BCN and obtained from Participating Provider or a Participating facility upon discharge. Medically Necessary special features are covered In-Network if prescribed by the treating physician, Preauthorized by BCN and obtained from a Participating Provider.

Coverage includes but is not limited to the following:

- Implantable or non-implantable breast prostheses required following a Medically Necessary mastectomy
- Repair, replacement, fitting and adjustments 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 (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

In-Network Benefits	Out-of-Network Benefits
Covered in full	Not Covered

Internal Implantable Prosthetic Devices

Your Inpatient, Outpatient or office visit Benefit applies The Cost Sharing applies toward the applicable Out-of-Pocket Maximum

Limitations – In-Network Benefit

- The item must meet the Coverage definition of a Prosthetic or Orthotic device
- Be Preauthorized by BCN

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- Obtained from a BCN-approved supplier
- Prescribed by the Primary Care Physician or a Professional Provider
- 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 may be prescribed.
- Any special features 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 stockings
- 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

8.22 Organ and Tissue Transplants

We cover organ or body tissue transplant and all related Services. The following conditions must be met:

- It is considered non-experimental in accordance with generally accepted medical practice
- It is Medically Necessary
- Preauthorized by BCN
- Performed at a BCN-designated transplant Facility. A **designated facility** is one that BCN determines to be qualified to perform a transplant.

Donor Coverage

Donor Coverage for a BCN Recipient

- For a Preauthorized transplant, we cover the necessary Hospital, surgical, laboratory and X-ray services for a Member and non-Member donor without any Cost Sharing.

Donor Coverage for a non-BCN Recipient

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- Member donor Cost Sharing may apply (as defined in your Certificate or Riders) when Preauthorized if the recipient's health plan does not cover BCN Member donor charges.

Cost Sharing does apply (as defined in this Certificate and Riders) if the recipient's coverage does not cover the BCN donor charges.

Cost Sharing

In-Network and Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Must be performed at a BCN-approved transplant facility Applies toward In-Network Out-of-Pocket Maximum

Exclusions from In-Network and Out-of-Network Benefits include but are not limited to

- Community wide searches for a donor

8.23 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 includes the following:

- 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
- 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 severe inflammation including but not limited to the following procedures
    - Blepharoplasty of upper lids
    - Panniculectomy
    - Rhinoplasty
    - Septorhinoplasty

We cover reconstructive surgery as defined above when it is Medically Necessary and Preauthorized by BCN.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits

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20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

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

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services Applies toward In-Network Out-of-Pocket Maximum	50% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services Applies toward Out-of-Network Out-of-Pocket Maximum

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

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services Applies toward In-Network Out-of-Pocket Maximum	50% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services Applies toward Out-of-Network Out-of-Pocket Maximum

8.24 Oral Surgery

We cover Medically Necessary Services listed below when Preauthorized by BCN.

- 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

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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.

NOTE: If performed Inpatient, Inpatient Benefit will apply.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Applicable Cost Share will apply based on site of care Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible for professional, Facility and related services when performed in an Outpatient setting Applies toward Out-of-Network Out of Pocket Maximum

Exclusions for In-Network and Out-of-Network Benefits include but are 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 procedure in preparation for the dental implant such as bone grafts

See Section 9 for additional exclusions and limitations.

8.25 Temporomandibular Joint Syndrome (TMJ) Treatment

Definition

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

We cover Medically Necessary Services and treatment for TMJ listed below when Preauthorized by BCN.

- Primary Care Physician and specialty office visits 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

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible of all fees	50% Coinsurance of the Approved Amount after Out-of-Network

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associated with Facility, professional and related services Applies toward In-Network Out-of-Pocket Maximum	Deductible of all fees associated with Facility, professional and related services Applies toward Out-of-Network Out of Pocket Maximum

Exclusions for In-Network and Out-of-Network Benefits include but are not limited to

Important: Dental services are not covered.

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

8.26 Orthognathic Surgery

Definition

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

Coverage

We cover Medically Necessary Services listed below when 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

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services Applies toward In-Network Out-of-Pocket Maximum	50% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services Applies toward Out-of-Network Out of Pocket Maximum

Exclusions for In-Network and Out-of-Network Benefits include but are not limited to

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

8.27 Weight Reduction Procedures

We cover surgery and procedures for weight reduction when Medically Necessary based on BCN's medical criteria and established guidelines related to the procedure. Your provider approves the service and must notify BCN prior to the procedure taking place.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
50% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services for all weight reduction procedures Applies toward In-Network Out-of-Pocket Maximum	Not Covered
Benefit Maximum Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary as determined by BCN	

8.28 Prescription Drugs and Supplies

Prescription drugs and supplies are covered only if the prescribing provider certifies to BCN and BCN agrees that the Covered drug in question is Medically Necessary for the Member, based on BCN's approved criteria. Those Covered drugs are not payable without Prior Authorization by BCN.

A) Prescription Drugs Received while you are an Inpatient

We cover prescription drugs and supplies as medical Benefits when prescribed and received during a Covered Inpatient Hospital stay.

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
- Preauthorized BCN
- 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.

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- 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.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
Cancer Drug Therapy - Covered in full Cost of administration - 20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	Cancer Drug Therapy - Covered in full Cost of administration - 40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket Maximum

Coordination of Benefits for cancer therapy drugs: If you have coverage through another plan in addition to your BCN Prescription Drug coverage, your BCN Prescription Drug Rider or your other plan will cover drugs for cancer therapy that are self-administered first before Coverage under this Certificate will apply.

C) Injectable and Infusible Drugs

The following drugs are covered as medical benefits:

- Injectable and infusible drugs administered in a Facility setting
- Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or Outpatient Facility

We may require selected Drugs be obtained through a BCN designated supplier. BCN will manage the treatment setting for injectable and infusible drug services and may direct you to a select location approved by BCN for the administration of the drug. Selected injectable drugs in certain categories and drugs that are not primarily intended to be administered by a Health Professional are covered through your BCN Prescription Drug Rider attached to this Certificate.

Cost Sharing

In-Network Benefits	Out-of-Network Benefits
20% Coinsurance of the Approved Amount after In-Network Deductible Applies toward In-Network Out-of-Pocket Maximum	40% Coinsurance of the Approved Amount after Out-of-Network Deductible Applies toward Out-of-Network Out-of-Pocket maximum
NOTE: Injectable Drugs related to services with 50% Coinsurance will apply 50% Coinsurance of the Approved Amount after Deductible to those injectables.	

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Exclusions for In-Network and Out-of-Network Benefits include but are not limited to

- Drugs not approved by the FDA
- Drugs not reviewed or approved by BCN
- Experimental or investigational drugs as determined by BCN
- Self-administered drugs as defined by the FDA are not covered under your medical benefit. This includes self-administered drugs for certain diseases such as:
  - Arthritis
  - Hepatitis
  - Multiple sclerosis
  - Certain other illnesses or injuries

  Self-administered drugs are covered only when you have a BCN Prescription Drug Rider.

D) Cellular and Gene Therapy

Definitions

Cellular and Gene Therapies – Products that involve the use of human cells or genetic modification to treat disease. The products that BCN considers to be Cellular and Gene Therapies are listed at: bcbsm.com/cellgenetherapy

Accelerated Approval Pathway - An FDA process that allows for earlier approval of certain drugs, including Cellular and Gene Therapies that have not yet demonstrated actual clinical benefit(s).

Primary Endpoint – The main outcome(s) the trial is designated to evaluate.

Coverage

We cover the following Cellular and Gene Therapies:

- For cancer indications

  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.
- For non-cancer indications that have been proven to be effective, as determined by BCN. BCN considers a Cellular and Gene Therapy to be effective to treat a condition if the following are true:
  - The drug has full FDA approval that was not obtained under the FDA's Accelerated Approval Pathway; and
  - The drug met all of its Primary Endpoint(s) in its pivotal trials; or
  - If confirmatory trials were required, the drug met its Primary Endpoint(s) in its confirmatory trial(s)

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Exclusions include but are not limited to:

- Cellular and Gene therapies for non-cancer indications that have not been proven effective as determined by BCN

E) Outpatient Prescription Drugs

Outpatient prescription drugs and supplies are covered under your BCN Prescription Drug Rider attached to this Certificate.

8.29 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 FDA
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the 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 FDA when there are any remaining unanswered questions about a drug, device or treatment

Life-Threatening Condition means any disease or condition from which the likelihood of death is probable 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:

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- 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
- The Member provides medical and scientific information establishing that the Member's participation in the trial would be appropriate because they meet the trial's protocol

Routine Patient Costs means all covered items and services related to an approved clinical trial, as defined under this Certificate or any associated Riders, that would be covered even if the Member was not enrolled in an Approved Clinical Trial.

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 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 associated Riders when they are related to conventional treatment
- The Experimental treatment and related Services are provided during BCN-approved clinical trial (check with your provider to determine whether a Clinical Trail 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. Your In-Network and Out-of-Network applies.

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 (e.g., monthly CT scans for a condition usually requiring only a single scan), or
- Items and services customarily provided by the research sponsors free of charge for an enrollee in the trial
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Routine patient costs for Phase I clinical trials whose primary purpose is not for therapeutic intent (e.g. prolongation of life, shrinkage of tumor, or improved quality of life, even in absence of cure or dramatic improvement of a condition)
- Administrative costs related to Experimental treatment or for research management
- Coverage for Services not otherwise covered under this Certificate

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- 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
- Use of transition technologies as a routine service in an Approved Clinical Trial such as cellular or gene therapies that have not been FDA approved for those indications

8.30 Gender Affirming Services

Definition

Gender Dysphoria
A condition classified as emotional discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

Gender Affirming Services
A collection of services that are used to treat Gender Dysphoria. These services must be considered Medically Necessary and may include hormone treatment and gender affirming surgery, as well as counseling and psychiatric services.

Coverage

We cover Gender Affirmation Services when determined to be Medically Necessary and Preauthorized by BCN. The Provider must supply documentation supporting that you meet the BCN medical criteria and established guidelines.

Cost Sharing

Your Inpatient and Outpatient In-Network or Out-of-Network Benefit Cost Sharing applies including office consultations as defined in the applicable Riders associated with your plan.

Exclusions include but are not limited to

- Gender Affirming Services that are considered cosmetic
- Experimental or investigational treatment

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Section 9: Exclusions and Limitations

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

9.1 Unauthorized Services

Select health, medical and hospital Services are covered only if Preauthorized by BCN.

9.2 Services Received While a Member

We will only pay for Covered Services you receive while you are a Member and covered under the Certificate and attached Riders. A Service is considered to be received on the date you have the service or get a supply. We can collect from you all costs for Covered Services that you receive after your Coverage ends, plus our cost of recovering those charges (including attorney's fees). Once your Coverage under this Certificate ends, any attached Riders to this Certificate will automatically end without further action or notice by BCN.

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 these services:

- 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 or immigration are a covered benefit)
  - Licenses and marriage license application
  - Legal proceedings such as parole, court and paternity requirements
  - School purposes, camp registration, 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
- Inpatient hospital stays, when Acute Care as an inpatient is not necessitated by the Member's condition when safe and adequate care can be received as an outpatient or in a less intensified medical setting
- Expenses of travel, transportation, 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

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- Fees incurred for collections, processing and storage of blood, cells, tissue, organs or other bodily parts in a family, private or public cord blood bank or other facility without immediate medical indication
- Testing to determine 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 practice of the servicing provider
- Late fees
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Psychoanalysis
- 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. These centers and programs are not considered residential treatment facilities.
- 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 Coverage (i.e., are not medically necessary) such as treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- 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 like
    - Dance therapy
    - Art therapy
    - Equine therapy
    - Ropes courses
    - Music therapy
    - Yoga and other movement therapies

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- Guided imagery
- Consciousness raising
- Socialization therapy
- Social outings and education/preparatory courses or classes
- Programs associated with disorders of consciousness for individuals in any of the following states of consciousness including, but not limited to, coma, cognitive motor disassociation, vegetative/unresponsive wakefulness or minimally conscious state using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation

9.5 Cosmetic Surgery

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

We do not pay for cosmetic surgery including but not limited to:

- Cosmetic surgery
- Elective rhinoplasty
- Spider vein repair
- Breast augmentation

Any related service such as pre-surgical care, follow-up care and reversal or revision of surgery is not covered.

9.6 Prescription Drugs

We do not pay for the following drugs:

- 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 offered by your Group and added to your Coverage.

9.7 Military Care

We do not pay for 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

Custodial Care is used for maintaining your basic need for food, shelter, housekeeping services, clothing and help with activities of daily living. **We do not pay for Custodial Care.**

This means that Custodial Care is not covered in your home, a nursing home, residential institution such as three-quarter or half-way house placement or any other setting that is not required to support medical and Skilled Nursing care.

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9.9 Comfort Items

We do not pay for comfort or convenience items:

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

9.10 Court Related Services

- We do not cover court ordered services including but not limited to pretrial and court testimony, court-ordered exams or the preparation of court-related reports that do not meet healthcare coverage requirements
- We do not cover court-ordered treatment for substance use disorder or mental illness except when services are medically necessary and meet the requirements 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's engagement in an illegal occupation

9.11 Elective Procedures

We do not pay for elective procedures:

- Reversal of a surgical sterilization
- In vitro fertilization (IVF)procedures, such as GIFT(gamete intrafallopian transfer) or ZIFT (zygote intrafallopian transfer) and all related services
- Artificial insemination except for treatment of infertility
- Genetic testing and counseling for non-members for any purpose

9.12 Maternity Services

We do not pay for these maternity services:

- Lamaze, parenting or other similar classes
- Services and supplies provided by a lay-midwife for home births
- All services provided to non-member surrogate parents
- Services provided to the newborn if one of the following apply:
  - The newborn's gestational parent is not covered under this Certificate on the newborn's date of birth
  - The newborn is covered under any other healthcare benefit plan on their date of birth
  - The Subscriber directs BCN not to cover the newborn's services
  - Services provided to the newborn occur after the 48 or 96 hours defined under the gestational parent's maternity care benefit

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9.13 Dental Services

We do not pay for dental services:

- Routine dental services and procedures
- Diagnose or treatment 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 Oral Surgery;
- 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

9.14 Services Covered Through Other Programs

We do not pay for services covered through other programs:

- 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 is the chapter that describes the rules of your healthcare coverage.)
- Under any public healthcare, 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)

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9.15 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.

9.16 Vision Services

We do not pay for vision services:

- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Routine non-Medically Necessary vision and optometric exams
- Refractions, unless Medically Necessary
- Glasses, frames and contact lenses except as defined in the Certificate
- Dilation
- Visual training or visual therapy for learning disabilities such as dyslexia

9.17 Hearing Aid Services

We do not pay for hearing aids, services or items:

- 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 or a summary of findings
- Hearing aid evaluation assessment tests 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
- Bone anchored hearing devices or surgically implanted bone conduction hearing aid
- Conformity evaluation test to verify receipt of the hearing aid, evaluate its comfort, function and effectiveness or adjustments to the hearing aid

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9.18 Out of State Services

Services received outside of Michigan are administered through Inter-Plan Programs. Please refer to the Inter-Plan Programs addendum for specific details on how services are paid. It tells you what you must pay under the exclusions and limitations of this addendum.

Non-routine elective services provided through Inter-Plan Programs must be Preauthorized by BCN and must follow all BCN Coverage provisions.

Coverage outside of the United States is limited to medical emergencies and urgent care services.

For more information about Out of State Services go to https://www.bcbsm.com/ or call Customer Service at the number shown on the back of your BCN ID card.

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We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

ملحوظة: إذا كنت تتحدث اللغة الكردية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다.
877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination is against the law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 888-605-6461, TTY: 711
Fax: 866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/