
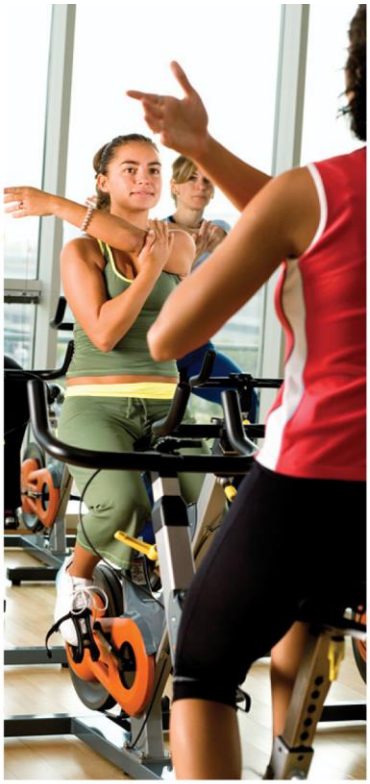




Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

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

Blue Care Network 10-Day Money-Back Guarantee

Blue Care Network is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCN in writing within 10 days of the effective date of your coverage. You will receive a full refund of your premium. If you terminate your coverage after 10 days, you will receive a pro-rated refund on the unused portion of your premium.

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

This certificate describes the benefits provided under your coverage. It includes General Provisions and Your Benefits.

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

When you enroll, you understand that:

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

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

This certificate and any attached riders are issued by BCN and is a contract between you, as an enrolled member and BCN.

By choosing to enroll as a BCN member, you agree to abide by the rules as stated in the General Provisions and Your Benefits chapters. You also recognize that, except for emergency health services, only those health care services provided by your primary care physician or arranged and approved by BCN are covered under this certificate. You are entitled to the benefits as described in this certificate in exchange for the premium paid to BCN.

IMPORTANT HEALTH SAVINGS ACCOUNT INFORMATION

This HDHP is a health plan that contains certain requirements set by the Internal Revenue Service with respect to deductible amount and out-of-pocket limits. A qualifying HDHP has a minimum annual deductible and maximum out-of-pocket limits. The HDHP does not offer copayments and coinsurance for pharmacy and medical services prior to satisfying the annual deductible.

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

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

You cannot establish and contribute to an HSA unless you have coverage under a HDHP. Your HSA money can be used to help pay your deductible, copayments, coinsurance and qualified medical expenses not covered by this plan.

Only services incurred after you establish your HSA are considered qualified medical expenses. Expenses incurred before you establish your HSA are not considered qualified medical expenses.

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

If you have questions about this coverage, contact BCN Customer Service department.

Blue Care Network
MC A02A
26255 American Drive
Southfield MI 48034
1-800-662-6667
https://www.bcbsm.com/

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 subsequent 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 that is enrolled with BCN as either a subscriber or family dependent.

24/7 Virtual Visit
A structured real-time virtual health consultation using secure audio-visual technology to connect with a Blue Cross selected vendor. The visit is for the purpose of diagnosing and providing medical treatment for urgent non-life-threatening conditions. Contact is initiated by the member you and must be within the provider's scope of practice.

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

Acute Illness or Injury
Characterized by sudden onset (following an injury) or presents an exacerbation of a disease and is expected to last a short period after treatment by medical or surgical intervention.

Approved Amount
The lower of the billed charge or our maximum payment level for the covered service. Any cost sharing that you owe is subtracted from the approved amount before we make our payment.

Assertive Community Treatment
A service-delivery model that provides intensive, locally based treatment to people with serious persistent behavior health conditions.

Balance Billing
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
A covered health care service that your plan helps pay for as described in this certificate.

Blue Care Network (BCN)
A 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
A period of time beginning January 1 and ending December 31 of the same year.

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

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

Coinsurance
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. Your coinsurance is added or amended when a rider is attached. The coinsurance applies to the out-of-pocket maximum.

Collaborative Care Management
An integration of medical and behavioral health treatment that allows a primary care physician team and a consulting psychiatrist to care for members' medical and behavioral health conditions using an outcomes-based model to control costs.

Continuity of Care
Seamless, continuous care rendered by a specific provider that if interrupted, could have negative impacts on the specific condition or disorder for which the patient is being treated. Continuity of care also includes ongoing coordination of care in high-risk patients that have multiple medical conditions.

Contraceptive Counseling
A preventive care service that helps you choose a contraceptive method.

Contract
This certificate and any related riders, your signed application for coverage and your BCN ID card.

Coordination of Benefits (COB)
Process for determining which certificate or policy is responsible for paying first for covered services (primary carrier) when a member has coverage under more than one policy.

Copayment (Copay)
A fixed dollar amount you owe for certain covered services usually when you receive the service. A copayment is added or amended when a rider is attached. Your copayment is not altered by an audit or recovery. Copayment amounts might be different for different health care services. For example, your emergency room copayment might be higher than your office visit copay. Copayments apply toward the out-of-pocket maximum.

Cost Sharing (Deductible, Copayment and/or Coinsurance)
The portion of health care costs you owe as defined in this certificate and attached riders. We pay the rest of the approved amount for covered services.

Covered Services
A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCN, to order or perform the service.

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

Deductible
The amount that you owe for health care 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
An eligible individual, under the age of 26, who is the child in relation to the subscriber or spouse by birth, legal adoption or for whom the subscriber or spouse has legal guardianship.

A principally supported child is not a dependent child for purposes of this certificate. See definition of principally supported child below.

Elective Abortion
The intentional use of an instrument, or other substance or device to terminate a pregnancy that doesn't meet the definition of non-elective abortion.

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

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

Enrollment
The process of submitting a completed enrollment form and paying the necessary premium to BCN to receive coverage.

Experimental Treatment
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
A hospital or facility that offers acute care or specialized treatment, including, but not limited to, substance use disorder treatment, rehabilitation treatment, skilled nursing care or physical therapy.

Family Dependent
An eligible family member who is enrolled with BCN for health care coverage. A family dependent includes dependent children and a dependent under a qualified medical child support order but does not include a principally supported child. Family dependents must meet the requirements stated in Section 1.

General Provisions
It describes the rules of your health care Coverage. See Chapter 1.

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

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

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

High Deductible Health Plan (HDHP)
A health plan with a minimum annual deductible and out-of-pocket maximum. These minimum and maximums are determined annually by the Internal Revenue Service and are subject to change. HDHP requires members to pay for all covered services, except preventive care services, until the deductible is met.

Hospital
A participating 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 disorders or pulmonary tuberculosis.

Inpatient
A hospital admission where 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 health care 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
A specialty hospital that focuses on treating member s requiring extended intensive care; meets BCN qualification standards and is certified by Medicare as an LTACH.

Medical Director
When used in this certificate, BCN's Chief Medical Officer ("CMO") or a designated representative.

Medically Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

Medical Necessity or Medically Necessary Services
Health care services provided to a 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 health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease
- Not regarded as experimental by BCN, and
- Rendered in accordance with BCN Utilization Management Criteria.

Member
Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered drugs or services.

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

Non-Elective Abortion
Services that meet federal funding guidelines:

- In the case of a physical disorder, physical injury, or physical illness, including a 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

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.

Nonparticipating Provider
Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCN to accept our payment as payment in full. Some nonparticipating providers, however, may agree to accept our payment on a per claim basis. You may be billed directly by the nonparticipating provider and will be responsible for the entire cost of the service.

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

Online/Virtual Visit
A structured real-time online health consultation using secure audio-visual technology to connect a BCN participating 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
A period of time set each year by BCN when you can enroll or disenroll in BCN.

Out-of-Pocket Maximum
Is the most you have to pay for covered services during a calendar year. The out-of-pocket maximum includes your medical and pharmacy deductible, copayment and coinsurance. This limit never includes your premium, balance billed charges or health care Services 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. Your out-of-pocket maximum amount is reflected in a rider attached to this certificate.

Participating Provider
An individual provider, facility or other health care 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 deductible, copayments, and coinsurance.

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.

PCP Referral
Process by which the primary care physician (PCP) directs you to a referral physician (specialist) prior to a specified service or treatment plan. The PCP coordinates the referral and any necessary BCN preauthorization.

Physical Medicine
A branch of medicine that specializes in the diagnosis, treatment, and management of patients who have been disabled from a disease, condition, disorder, or injury. Services include by not limited to:

- Manipulation
- Traction
- Massage
- Exercise
- Heat

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

Premium
The amount prepaid monthly for health care coverage.

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

Primary Care Physician (PCP)
The participating physician you choose to provide and coordinate all of your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Principally Supported Child
An individual less than 26 years of age for whom principal financial support is provided by the subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for coverage. A principally supported child must meet the requirements in Section 1.

A principally supported child is not the same as a dependent child.

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

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- 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)
- Certified Nurse Practitioner (CNP)
- Clinical Nurse Specialist-Certified (CNS-C)
- Licensed Behavior Analyst (LBA)
- Doctor of Chiropractic (DC)
- Physician Assistant (PA)
- Board-Certified Athletic Trainers (BCAT)
- Licensed Genetic Counselor (LGC)
- Other providers as identified by BCN

Referral
The process by which the primary care physician (PCP) directs you to a referral physician (specialist) prior to a specified service or treatment plan. The PCP coordinates the referral and any necessary BCN preauthorization.

Referral Physician (Specialist)
A provider you are referred to by your primary care physician (PCP).

Rehabilitation Services
Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Respite Care
Relief to family members or other persons caring for terminally ill persons at home.

Rider
A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Routine
Non-urgent, non-emergency, non-symptomatic medical care provided for the purpose of disease prevention.

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

Service Area
Geographic area made up of counties or parts of counties, where we are authorized by the state of Michigan to market and sell our health plans. The majority of our participating providers are located in the service area.

Skilled Care
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), and 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.

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

Subscriber
The person who signed and submitted the application for coverage.

Surprise Billing
An instance where a member unknowingly receives care from a nonparticipating provider or receives care from a nonparticipating 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
Real-time health care services 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 can be initiated by the member or provider and must be within your provider's scope of practice for both medical and behavioral health services.

Urgent Care Center
Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or professional providers' offices.

Your Benefits
A detailed description of health care coverage including exclusions and limitations. See Chapter 2.

Table of Contents

Topic	Page
Definitions	iii
CHAPTER 1 – GENERAL PROVISIONS	
Definitions	iii
SECTION 1: Eligibility, Enrollment and Effective Date of Coverage	**1**
1.1 Subscribers	1
1.2 Family Dependents Eligibility	2
1.3 Dependent Under a Qualified Medical Child Support Order	4
1.4 Principally Supported Child	5
1.5 Additional Eligibility Guidelines	5
SECTION 2: Other Party Liability	**6**
2.1 Non-Duplication	6
2.2 Coordination of Benefits	7
2.3 Subrogation and Reimbursement	11
SECTION 3: Member Rights and Responsibilities	**14**
3.1 Confidentiality of Health Care Records	14
3.2 Inspection of Medical Records	14
3.3 Primary Care Physician (PCP)	14
3.4 Grievance Procedure	15
3.5 Continuity of Care for Professional Services	19
3.6 Additional Member Responsibilities	22
3.7 Preauthorization Process	23
3.8 Pediatric Dental Essential Health Benefit	23
SECTION 4: Forms, Identification Cards, Records and Claims	**24**
4.1 Forms and Applications	24
4.2 Identification Card	24
4.3 Misuse of Identification Card	24
4.4 Membership Records	25
4.5 Authorization to Receive Information	25
4.6 Member Reimbursement	25
SECTION 5: Termination of Coverage	**26**
5.1 Termination of Coverage	26
5.2 Termination for Nonpayment	26
5.3 Termination of a Member's Coverage	27
5.4 Extension of Benefits	28
SECTION 6: Continuation Coverage	**29**
6.1 Loss of Coverage by Dependent	29

SECTION 7: Additional Provisions 30
7.1 Notice 30
7.2 Change of Address 30
7.3 Headings 30
7.4 Governing Law 30
7.5 Execution of Contract of Coverage 30
7.6 Assignment 30
7.7 Policies, Member Handbook and Welcome Kit 30
7.8 Time Limit for Legal Action 31
7.9 Your Contract 31
7.10 Reliance on Verbal Communication and Waiver by Agents 31
7.11 Amendments 32
7.12 Major Disasters 32
7.13 Obtaining Additional Information 32
7.14 Right to Interpret Contract 33
7.15 Independent Contactors 33
7.16 Clerical Errors 33
7.17 Waiver 33
7.18 Information About Your Bill and Termination of Coverage 33
7.19 Unlicensed and Unauthorized Providers 35
7.20 Special Programs 35
7.21 Surprise Billing 36
7.22 Experimental Treatment 37

SECTION 8: Your Benefits 41
8.1 Cost Sharing 41
8.2 Medical Professional Physician Services 43
8.3 Preventive and Early Detection Services 45
8.4 Inpatient Hospital (Facility) Services 48
8.5 Outpatient Services 50
8.6 Emergency and Urgent Care 50
8.7 Ambulance 53
8.8 Reproductive Care and Family Planning 56
8.9 Skilled Nursing Facility 60
8.10 Hospice Care 60
8.11 Home Health Care Services 61
8.12 Home Infusion Therapy Services 62
8.13 Behavioral Health Services (Mental Health and Substance Use Disorder) 63
8.14 Autism Spectrum Disorders 66
8.15 Outpatient Therapy Services 69
8.16 Durable Medical Equipment 71
8.17 Diabetic Supplies, Equipment and Outpatient Diabetes Management Program (ODMP) 73
8.18 Prosthetics and Orthotics 74
8.19 Organ and Tissue Transplants 76
8.20 Reconstructive Surgery 76
8.21 Oral Surgery 77
8.22 Temporomandibular Joint Syndrome (TMJ) Treatment 78

8.23 Orthognathic Surgery 79
8.24 Weight Reduction Procedures 79
8.25 Prescription Drugs and Supplies 80
8.26 Clinical Trials 82
8.27 Gender Affirming Services 85
8.28 Collaborative Care Management 86
8.29 Enhanced Condition Management Program (ECMP) 88

SECTION 9: Exclusions and Limitations 89
9.1 Unauthorized and Out-of-Network Services 89
9.2 Services Received While a Member 89
9.3 Services That Are Not Medically Necessary 89
9.4 Non-Covered Services 90
9.5 Cosmetic Surgery 93
9.6 Prescription Drugs 93
9.7 Military Care 94
9.8 Custodial Care 94
9.9 Comfort Items 94
9.10 Court Related Services 94
9.11 Elective Procedures 94
9.12 Maternity Services 95
9.13 Dental Services 95
9.14 Services Covered Through Other Programs 96
9.15 Alternative Services 96
9.16 Vision Services 97
9.17 Hearing Aid Services 97
9.18 Out-of-Area Services/Inter-Plan Claims Processing 97
We Speak Your Language 100
Discrimination Is Against The Law 102

INDEX 103

CHAPTER 1 - GENERAL PROVISIONS

SECTION 1: Eligibility, Enrollment and Effective Date of Coverage

This section describes eligibility, enrollment and effective date of coverage. All subscribers and members must meet eligibility requirements set by BCN.

Certain requirements depend on whether the member is a:

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

If you are a minor child, you are eligible for child-only benefits.

If more than one child is in a family, each must have their own contract and be named as the subscriber.

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

1.1 Subscribers

Eligibility

You are eligible for coverage under this certificate if:

- You are a current resident of Michigan on the effective date of coverage and a U.S. citizen or legally present and must intend to live in the state except in the case of individuals living outside of Michigan temporarily (as in the case with college students or snowbirds); and

- Are not enrolled in Medicare

To persons who become eligible for Medicare coverage after enrolling in this certificate.

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

If you are enrolled in Medicare and a service is covered under Medicare, benefits will not be payable under this certificate.

Enrollment

When you can enroll:

- During the annual open enrollment period
- At any other time, due to a qualifying event, including but not limited to:
  - A birth
  - A change in marital status
  - Loss of a job
  - Loss of group coverage
- At other times of the year as allowed by federal law

Effective Date

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

1.2 Family Dependents Eligibility

A family dependent may be:

- The legally married spouse of the subscriber
- A dependent child – subscriber's child including natural child, stepchild, legally adopted child or child placed for adoption or foster child placed 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.

Newborn children, including grandchildren, may qualify for limited benefits immediately following their birth even though they are not listed on your contract. If the newborn's birth parent 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
- A dependent due to any other court 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 in coverage and who is totally and permanently disabled may continue coverage if:

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

Family Dependents Eligibility (continued)

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 child turns age 26.

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

A dependent child whose only disability is a learning disability or substance use disorder does not qualify for health care coverage under this exception.

Enrollment

When you can add eligible family dependents to the subscriber's contract:

- During the annual open enrollment
- When the subscriber enrolls
- Within 60 days of a "qualifying event," that is, birth, marriage, placement for adoption, Qualified Medical Child Support Order, or foster care placement.

See below for additional requirements for dependents under a Qualified Medical Child Support Order.

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

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 based on your qualifying event or special enrollment period as defined by PPACA. If the family dependent is not enrolled within 60 days, coverage will not begin until the next open enrollment period's effective date.
- For a family dependent who lost coverage and notifies BCN within 60 days, coverage will be effective based on PPACA guidelines. If you do not notify BCN within 60 days, coverage will not begin until the next open enrollment period's effective date.
- Adopted children are eligible for coverage from the date of placement or the first of the following month.

Placement means when the subscriber becomes totally responsible for the child; therefore, the child's coverage may begin before the child lives in the subscriber's home.

1.3 Dependent Under a Qualified Medical Child Support Order

Eligibility

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

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

Enrollment

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

In addition:

- If the subscriber parent who is under court order to provide coverage does not apply, the other parent **or** the state Medicaid agency may apply for coverage for the child.

- A subscriber parent who has individual coverage must change from individual coverage to family coverage.

  

  Rates will increase for family coverage.

- If the parent, who is under a court or administrative order to provide coverage for the child, is not already a subscriber, that parent may enroll (if eligible) when the child is enrolled.

- Neither parent may disenroll the child from an active contract while the court or administrative order is in effect, unless the child becomes covered under another plan.

Effective Date of Coverage

- If BCN receives notice within 60 days of the court or administrative order, coverage is effective as of the date of the order or as of the date defined by PPACA.

- If BCN receives notice later than 60 days from the date of the order, coverage is effective on the date BCN receives notice.

1.4 Principally Supported Child

Eligibility

A principally supported child must:

- Not be the child of the subscriber or spouse by birth, legal adoption or legal guardianship
- Be 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 and enrolled in Medicare
- Be dependent on the subscriber for principal financial support in accordance with Internal Revenue Service standards and have met these standards for at least 6 full months prior to applying for coverage.

Enrollment

You may apply for coverage for a principally supported child after you have been the principal support for 6 months. Coverage will begin 3 months after the application is accepted by BCN.

To apply, you must furnish the following:

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

Effective Date of Coverage

Coverage for a principally supported child begins on the first day of the month, 3 months after application and proof of support is received and accepted by BCN.

The premium payment must have been received by BCN prior to the effective date of coverage.

1.5 Additional Eligibility Guidelines

The following guidelines apply to **all** members:

- **Change of Status**: You agree to notify BCN within 60 days of any change in eligibility status of you or any family dependents. When a member is no longer eligible for coverage, they are responsible for payment for any services or benefits.

- We will only pay for covered services you receive when you are a BCN member covered under this certificate. If you are admitted to a hospital or skilled nursing facility either when you become a member or when your BCN membership ends, we will only pay for covered services provided during the time you were a member.

SECTION 2: Other Party Liability

IMPORTANT NOTICE

BCN does not pay claims or coordinate benefits for services that:

- Are not provided or preauthorized by BCN and a primary care physician
- Are not covered services under this certificate

It is your responsibility to provide complete and accurate information when requested by us 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.

Applicable to Members Who Participate with an HSA

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

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

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

- Automobile insurance
- Disability
- Dental care
- Vision care
- Long term care

2.1 Non-Duplication

- BCN coverage provides you with the benefits for health care services as described in this certificate.
- BCN coverage does not duplicate benefits or pay more for covered services than the BCN approved amount.
- BCN does not allow "double-dipping" meaning that the member and/or provider is not eligible to be paid by both BCN and another health plan or another insurance policy.
- This is a coordinated certificate, meaning coverage described in this certificate will be reduced to the extent that the services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for payment under such health plan or policy.

2.2 Coordination of Benefits

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

It is your responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charge.

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

Order of Benefit Payments

(2) The order in which benefits are payable by insurers that issue 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:

Order of Benefit Payments (continued)

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer 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 health care coverage for the dependent child's health care 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 insurer 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 health care expenses or health care 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 health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).

(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care 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.

Coordination of Benefits (continued)

Order of Benefit Payments (continued)

(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).

We do not pay for:

- Claims or coordinate benefits for services with incomplete member benefit coverage information.

It is your responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charge.

2.3 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 used in this section have the following meanings:

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

Collateral Source Rule
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
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
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
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
A legal doctrine that requires a plaintiff in a lawsuit be fully compensated for his or her damages before any subrogation liens may be paid.

Definitions (continued)

Other Equitable Distribution Principles
Any legal or equitable doctrines, rules, laws or statues that may reduce or eliminate all or part of BCN's claim of subrogation.

Plaintiff
A person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or representative of the injured party.

Your Responsibilities

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

In these cases:

- You assign to us your right to recover what BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a lien or right of recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held; 2) whether the money or other valuable consideration is designated as economic or non-economic damages; and 3) whether the recovery is partial or complete.
- You agree to inform BCN when your medical expenses should have been paid by another party but was not due to some act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your attorney of BCN's rights and your obligations under this certificate.
- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining written consent from BCN if the settlement relates to services paid by BCN.
- You agree to cooperate with BCN in our efforts to recover money we paid on your behalf.
- You acknowledge and agree that this certificate supersedes any made whole doctrine, collateral source rule, common fund doctrine or other equitable distribution principles.

- You acknowledge and agree that this certificate is a contract between you and BCN and any failure by you, other members on the contract or representatives to follow the terms of this certificate will be a material breach of your contract with us.

  a) When you accept a BCN ID card for coverage, you agree that, as a condition to receiving benefits and services under this certificate, you will make every effort to recover funds from the liable party.

  b) When you accept a BCN ID card for coverage, it is understood that you acknowledge BCN's right of subrogation. If BCN requests, you will authorize this action through a subrogation agreement. If a lawsuit by you or by BCN results in a financial recovery greater than the services and benefits provided by BCN, BCN has the right to recover its legal fees and costs out of the excess.

  c) When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and BCN, the costs and legal expenses will be divided equitably.

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

  e) BCN will have the right to recover from you the amount to which BCN has a right to subrogation. If you refuse or do not cooperate with BCN regarding subrogation, it will be grounds for terminating membership in BCN upon 30 days written notice. You have the right to appeal our decision by contacting Customer Service.

SECTION 3: Member Rights and Responsibilities

3.1 Confidentiality of Health Care Records

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

You agree to permit providers to release information to BCN. This can include medical records and claims information related to Services you may receive or have received.

BCN agrees to keep this information confidential. Consistent with our Notice of Privacy Practice, information will be used and disclosed only as preauthorized or as required by or as may be permissible under the law.

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

3.2 Inspection of Medical Records

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

3.3 Primary Care Physician (PCP)

BCN requires you to choose a primary care physician. You have the right to designate any primary care physician who is a participating physician and who is 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"). No PCP referral is required for a minor to receive pediatric services from the participating pediatrician.

You do not need preauthorization from BCN or from any other person, including your primary care physician, in order to obtain access to obstetrical or gynecological care from a participating provider who specializes in obstetric and gynecologic care. The participating specialist, however, may be required to comply with certain BCN procedures, including obtaining preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. The member retains the right to receive the obstetrical and/or gynecological services directly from her primary care physician.

Primary Care Physician (PCP) (continued)

Information on how to select a primary care physician, a list of participating primary care physicians, participating pediatricians and participating health care professionals (including certified and registered nurse midwives) who specialize in obstetrics or gynecology is available at http://www.bcbsm.com/ or by calling Customer Service at the number provided on the back of your BCN ID card.

If after reasonable efforts, you and the primary care physician are unable to establish and maintain a satisfactory physician-patient relationship, you may be transferred to another primary care physician. If a satisfactory physician-patient relationship cannot be established and maintained, you may be asked to disenroll upon 30 days written notice; all dependent family members will also be required to disenroll from coverage.

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 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 with or appeal a decision by BCN. There are no fees or costs charged to you when filing a grievance.

If you are a 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
Includes the following:

- A request for a benefit, on application of any utilization review technique, does not meet the requirements for medical necessity, appropriateness, health care 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
- 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
An appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

Post-Service Grievance
An appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

Review and Decision by the BCN Grievance Panel

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

Appeals and Grievance Unit
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 30 calendar days for pre-service and 60 calendar days for post-service.

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

If the grievance pertains to a clinical issue, the grievance will be forwarded to an independent Medical Consultant within the same or similar specialty for review. If BCN needs to request medical information, an additional 10 business days may be added to the resolution time. When an adverse determination is made, a written statement, in plain English, will be sent within 5-calendar days of the panel meeting, but not longer than 30-calendar days for pre-service and 60-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:
.

You may mail your request and the required forms that we give you to:

Office of Research, Rules and Appeals – Appeals Section
Department of Insurance and 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

You may also contact the Department with your request by phone, fax, or online:

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

External Review (continued)

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 or 60-calendar days for post-service (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 from the Department of Insurance and Financial Services. 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 above address. 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.

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 1-866-522-7345.

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 Continuity of Care for Professional Services

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 or facility may continue treating you for 90 days, or until you no longer have a medical condition qualifying you for continuity of care, whichever is shorter.

BCN will notify you after learning of the effective date of the provider's termination.

Continuity of Care for Existing Members

Provider Requirements

The continuity of care provisions apply only when your provider (physician or facility):

- Notifies BCN of their agreement that you qualify as a continuing care patient

- Continues to accept the BCN approved amount as payment in full for the services provided
- Continues to meet BCN's quality standards
- Continues to adhere to BCN medical and quality management policies and procedures
- Provides up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider

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

Complex Medical Conditions

Through continuity of care, you may continue your treatment if the following circumstances apply to you:

- 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
- 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 the former participating provider (including your primary care physician) agrees you are a continuing care patient and meets the "Provider Requirements" listed above, BCN will continue to provide coverage for the covered services when provided for an ongoing course of treatment for the "complex medical conditions" detailed above. In order for additional covered services to be paid, your participating primary care physician must provide or coordinate all such services.

You will be responsible for any amount charged by the nonparticipating provider if the above criteria are not met unless you obtain a referral to the physician from your primary care physician and authorization from BCN.

Continuity of Care for New Members

If you are a new member and want to continue an active course of treatment from your existing, nonparticipating provider, you may request enrollment in BCN's continuity of care program. In order for the services to be paid by BCN, at the time of enrollment you must have selected a primary care physician who will coordinate your care with the nonparticipating provider.

Eligibility criteria to participate in the continuity of care program include the circumstances described below. You have up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider.

Complex Medical Conditions

Through continuity of care, you may continue your treatment if the following circumstances apply to you:

- 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
- 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 for an ongoing course of treatment, subject to criteria detailed above. In order for additional covered services to be paid, your participating primary care physician must provide or coordinate all such services.

You will be responsible for any amount charged by the nonparticipating provider if the above criteria are not met unless you obtain a referral to the physician from your primary care physician and authorization from BCN.

3.6 Additional Member Responsibilities

You have the responsibility to do the following:

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

3.7 Preauthorization Process

Some services and supplies require preauthorization by your primary care physician and/or BCN. Section 8 tells you which services and supplies need preauthorization. You can get a complete, detailed, and up-to-date list by contacting Customer Service or by visiting www.bcbsm.com/importantinfo; select *Approving Covered Services*. The list may change from time to time.

This chart describes the type of request, preauthorization procedures and time frames:

Prior Authorization Non-Urgent review: When you need a certain health care 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 health care 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 24 hours from receipt of the request

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.

3.8 Pediatric Dental Essential Health Benefit

The Affordable Care Act (ACA) requires that Qualified Health Plans (QHPs) like this one offer 10 Essential Health Benefits (EHBs). One benefit is pediatric dental coverage. This requirement applies to anyone who obtains medical coverage, regardless of their age.

Members over 18 years of age without dependents are still required to have the pediatric dental benefit EHB as part of their plans. This certificate satisfies the ACA requirement for pediatric dental coverage as part of a Qualified Health Plan. This certificate **does not** provide dental benefits to members over 18 years of age. There is **no rate** added to your premium to satisfy the ACA-mandated pediatric dental coverage.

To satisfy the ACA pediatric dental coverage mandate for members under 18 years of age, a stand-alone pediatric dental plan (SADP) is available. This SADP may be purchased by a subscriber who is 18 years of age on the plan's effective date, or by a subscriber with dependents under 18 years of age. Contact Customer Service for more information on how and when you may purchase a stand-alone pediatric dental plan.

SECTION 4: Forms, Identification Cards, Records and Claims

4.1 Forms and Applications

You must complete and submit any enrollment form or other forms that BCN requests. You represent that any information you submit is true, correct and complete.

The submission of false or misleading information in connection with coverage is cause for rescission of your contract upon 30 days written advance notice.

You have the right to appeal our decision to rescind your coverage by following the grievance procedure as described in Section 3 and online at 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, and its return may be requested at any time.

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

If you have not received your card or your card is lost or stolen, please contact **Customer Service immediately** by visiting http://www.bcbsm.com/. Information regarding your 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 the member submits information in a satisfactory format.
- If you or someone applying for coverage on your behalf misrepresents your tobacco use or state or county of residence, BCN has the right to recover from you the difference in premium between what you are paying and what you should have paid.
- You are responsible for correcting any inaccurate information provided to BCN. If you intentionally fail to correct inaccurate information, you will be responsible to reimburse BCN for any service paid based on the incorrect information.

4.5 Authorization to Receive Information

By accepting coverage under this certificate, you agree to the following:

- BCN may obtain any information from providers in connection with services provided to a member
- BCN may disclose any of your medical information to your primary care physician 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 copayments, 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 were 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 68767
Grand Rapids, MI 49516-8767

Proof of payment must be submitted within 12 months of the date of service. Claims submitted 12 months after the date of service will not be paid.

SECTION 5: Termination of Coverage

5.1 Termination of Coverage

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

- This certificate may be terminated by Blue Care Network with 31 days prior written notice, which shall include reason for termination. Benefits will terminate for subscriber and dependents as of the date of termination of this certificate.
- If the subscriber terminates this certificate, all rights to benefits shall cease as of the effective date of termination.

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

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

If you purchased coverage under this certificate on the marketplace, you may terminate it only if you contact the marketplace with proper notice.

5.2 Termination for Nonpayment

Nonpayment of Premium

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

Termination for Nonpayment (continued)

Nonpayment History

BCN may refuse to accept an application for enrollment or may decline renewal of any member's coverage if the applicant or any member on the contract has a history of delinquent payment of their share of the costs for covered services.

Nonpayment of Member's Cost Sharing

BCN may terminate coverage for a member under the following conditions:

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

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

5.3 Termination of a Member's Coverage

Termination*

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

- You no longer meet eligibility requirements
- Coverage is cancelled for nonpayment
- You 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
- We no longer offer this coverage
- BCN exits the individual market
- Your cessation of association membership

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

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 material fact may include:

- Misuse of the BCN ID card (Section 4)
- Intentional misuse of the BCN system
- Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to rescind your coverage by following the BCN grievance procedure in Section 3 of this certificate. You can also find this procedure at http://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.

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

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

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 of Coverage by Dependent

If a family dependent ceases to be eligible for coverage because of:

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

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

SECTION 7: Additional Provisions

7.1 Notice

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

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

7.2 Change of Address

You must notify BCN immediately if your address changes. Except as otherwise stated in this certificate, you must live within the BCN Service Area.

7.3 Headings

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

7.4 Governing Law

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

7.5 Execution of Contract of Coverage

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

7.6 Assignment

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, Member Handbook and Welcome Kit

Reasonable policies, procedures, rules and interpretation may be adopted in order to administer the certificate. Your benefits include additional programs and services, as set forth in your member account at http://www.bcbsm.com/.

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 claim review grievance and appeals procedure is unacceptable.

7.9 Your Contract

Your contract consists of the following:

- Certificate of coverage
- Any attached riders
- Your member handbook
- The application signed by the subscriber
- The BCN identification card

Your coverage is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us. BCN does not 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 claims payment. All claims are subject to a review of the diagnosis reported, verification of medical necessity, the availability of benefits at the time the claim is processed, as well as the conditions, limitations, exclusions, maximums, copayments, deductible and coinsurance under your certificate and attached riders.

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

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

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

7.11 Amendments

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

7.12 Major Disasters

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

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

Such circumstances include, but are not limited to:

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

7.13 Obtaining Additional Information

The following information is available:

- The current provider network in your service area
- The professional credentials of the health care providers who are participating providers
- The names of participating hospitals where individual participating physicians have privileges for treatment
- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider
- Information about the financial relationships between BCN and a participating provider
- Preauthorization requirements and any limitations, restrictions or exclusions on services, benefits or providers

Some of this information may be found in your member account at http://www.bcbsm.com/.

Obtaining Additional Information (continued)

You can obtain the information through these sources:

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

7.14 Right to Interpret Contract

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

7.15 Independent Contactors

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

7.16 Clerical Errors

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

7.17 Waiver

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

7.18 Information About Your Bill and Termination of Coverage

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

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

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

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

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

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

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

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

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

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

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

7.19 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.

7.20 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, enrollment/participation or compliance and adherence with select medical services/prescription drugs 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 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 standard cost-share. If you choose not to participate or are not eligible to participate in the program, you will pay the applicable cost share for the services defined in this certificate or associated riders.

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.

7.21 Surprise Billing

Federal and Michigan state law requires us to pay nonparticipating 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 cost share applicable to that service as defined in federal and Michigan law. The cost share you pay for these services will apply to your plan deductible if applicable and out-of-pocket maximum. The following situations are covered by the surprise billing laws:

- Covered emergency services at a participating or nonparticipating facility
- Covered non-emergency services provided by nonparticipating 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

7.22 Experimental Treatment

- We do not pay for:
- Experimental treatment. This includes experimental drugs and devices
- Services and administrative costs related to experimental treatment
- Costs of research management

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
- 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

The medical director may consider other sources

Experimental Treatment (continued)

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.

CHAPTER 2 – YOUR BENEFITS

Important Information

This certificate provides you with important information about your health care 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 are provided in accordance with certificate requirements (including referral from PCP or other participating providers) 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 referral or preauthorization is not a guarantee of payment. All claims are subject to:
  - Review of the diagnosis reported
  - Verification of medically necessary
  - Availability of benefits at the time the claim is processed
  - Conditions, limitations, exclusions, maximums
  - Coinsurance, copayments and deductible under your certificate
- If you receive services that we do not cover, you will pay for the services.
- Your PCP or other participating provider coordinates referrals and preauthorization.
  - For an updated list of services that require preauthorization, contact Customer Service or visit www.bcbsm.com/importantinfo; select *Approving Covered Services*.
- If there is an insufficient number of participating providers for a specific provider specialty within the BCN Service Area, you may obtain care from a nonparticipating provider only when referred by your PCP and preauthorized or approved by BCN.
- If you purchase a deluxe item or equipment when not medically necessary, the approved amount for the basic item applies toward the price of the deluxe item. You are responsible for any costs over the approved amount.
- Coverage is subject to the limitations and exclusions listed in this chapter.
- A rider may be attached to this certificate. It applies or revises copayments, coinsurance, deductible, out-of-pocket maximum and/or benefit maximums.
- When a rider is attached to this certificate, the rider will take precedence.
- BCN will manage or may direct your care to a surgical or treatment setting for select services.
- You can find information about other benefits as listed below, in the member handbook or at http://www.bcbsm.com/:
  - Disease management
  - Prevention
  - Wellness
  - Care management services

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://www.bcbsm.com/priorauth.

SECTION 8: Your Benefits

8.1 Cost Sharing

You may have to pay a deductible, copayment and/or coinsurance for covered services. A rider that amends this certificate will explain what cost sharing you must pay.

Cost Sharing = Deductible, Coinsurance and Copayment Calculation

If you have a coinsurance or copayment for a particular service as well as a deductible, you will first be responsible for the payment of the deductible. The coinsurance or copay will be based on the remaining balance of the approved amount. BCN will be responsible to make payment to the provider only after the deductible, coinsurance, and copays have been paid.

Deductible Requirements

The deductible is the amount you must pay each year before BCN will pay for covered services. A rider that amends this certificate will tell you how much it will be.

Your deductible is based on amounts defined annually by the federal government for High Deductible Health Plans. Your deductible renews each calendar year. It does not carry over to the new year.

The deductible does not apply to preventive services (Section 8.3).

The approved amount will be applied to the deductible for medical and pharmacy covered services. Charges paid by a member in excess of the approved amount or for non-covered services do not apply toward the deductible.

Copayment (Copay) Requirements

A copayment is a fixed dollar amount you must pay for certain covered services when you receive them. You are responsible for copayments defined in this certificate and any riders that amend this certificate. Copayments count toward your out-of-pocket maximum. Once you meet your out-of-pocket maximum, you will not be responsible for copayments for the remainder of the calendar year.

Coinsurance Requirements

Coinsurance (if any) is the portion of the approved amount that you must pay for covered services. A rider that amends this certificate will tell you if you must pay coinsurance for any covered services.

Coinsurance will not apply to preventive services (Section 8).

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay for covered services under this certificate and any attached riders per calendar year. A rider that amends this certificate will tell you how much it will be. The out-of-pocket maximum includes your BCN medical and BCN prescription drug deductible, copay(s) and coinsurance.

We base your out-of-pocket maximum on the amount defined annually by the federal government. Your out-of-pocket maximum renews each calendar year. It does not carry over to the new year.

Once your out-of-pocket maximum is met, no more deductible, copayments or coinsurance will be required for the remainder of the calendar year.

Payments for the following will not be applied to the out-of-pocket maximum:

- Any premium or contributions paid toward the premium
- Charges paid by you in excess of our approved amount
- Non-covered services

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.

Examples of covered services that have a benefit maximum include, but are not limited to:

- Medical rehabilitation and habilitative services
- Spinal manipulation
- Skilled nursing care

8.2 Medical Professional Physician Services

We cover the following services in full **after** you meet your deductible.

A) Physician services at an office site, hospital location, online visit, or 24/7 virtual visit:

- Primary care physician (PCP)
- BCN participating OB/GYN
- Referral physician

Provided by a BCN professional provider or Blue Cross selected vendor app 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 BCN professional provider in real time. The 24/7 virtual visit must allow the member to interact with the Blue Cross selected vendor in real time. Treatment and consultation recommendations made online or virtually, including writing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

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 visits and 24/7 virtual visits must meet BCN's standards for an evaluation and management visit.

Online visit and 24/7 virtual 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

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

Medical Professional Physician Services (continued)

B) **Maternity prenatal and postnatal office visits** when provided by your primary care physician or participating OB/GYN or participating certified nurse midwife.

- Routine prenatal maternity care is covered in full; deductible does not apply.
- Non-routine prenatal maternity care is covered in full after deductible.
- Postnatal care is covered in full; deductible does not apply.
- Maternity education is covered when provided by your PCP or participating OB/GYN.

If cost sharing rider is attached, cost sharing does not apply to routine prenatal or postnatal visits. The cost sharing does apply to non-routine (non-preventive) high-risk prenatal visits and postnatal care.

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

D) **Inpatient Professional Services** while you are in an inpatient hospital or skilled nursing facility or inpatient rehabilitation center when preauthorized by BCN and billed by a physician.

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

F) **Chiropractic Services and Osteopathic Manipulative Therapy** when provided by a BCN participating chiropractor or osteopathic physician, referred by your primary care physician and preauthorized by BCN.

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

Radiological services and X-rays are covered when preauthorized. See Outpatient Services section and any attached riders for cost-sharing information.

Benefit Maximum

Osteopathic manipulative therapies on any location of the body and chiropractic spinal manipulations to treat misaligned or displaced vertebrae of the spine are limited to the benefit maximum of 30 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 language, and occupational therapy services. Any combination of therapies (mechanical traction, physical medicine, or physical, speech language, and occupational therapy) is limited to a combined benefit defined under Outpatient Therapy section.

G) **Eye Care** — Treatment of medical conditions and diseases of the eye when services are referred by your primary care physician and preauthorized by BCN.

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.

An affiliated immunization pharmacy can be found through the Find Care option on your member account through BCN's secured member account. Medical evaluation by a pharmacist will apply the PCP office visit cost share as designated by your plan.

8.3 Preventive and Early Detection Services

We cover preventive and early detection services as defined in the federal Patient Protection and Affordable Care Act ("PPACA"). These services must be provided or coordinated by your primary care physician. Services are modified by the federal government from time to time.

Preventive care services include but are not limited to the following:

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

  Health screenings include but are not limited to:

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

- **Women's health and well-being**

  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
  - 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
  - Screening for sexually transmitted diseases; HIV counseling and screening
  - Contraceptive counseling and methods including measurement, fittings, insertion, removal, administration and management of contraceptive care as required by PPACA. FDA-approved contraceptive 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.
  - Maternity counseling for the promotion and support of breast-feeding, prenatal vitamin counseling and alternative fertility awareness methods
  - Routine preventive prenatal and postnatal office visits
  - 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 subsection for limitations and exclusions)
  - Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening

Preventive and Early Detection Services (continued)

Women's health and well-being (continued)

- Screening for gestational diabetes
- Screening for osteoporosis to prevent fractures
- Screening and counseling for intimate partner and domestic violence
- Voluntary sterilization of female reproductive organs including tubal ligation and related charges associated with the procedure (anesthesia, labs, etc.)
- Genetic counseling and BRCA testing if appropriate for those whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes

- **Newborn and well-child assessments and examinations**
- **Immunizations** (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN
- **Screening colonoscopy** and flexible sigmoidoscopy
- **Morbid Obesity Weight Management** - Dietician services billed by a physician or other provider recognized by BCN
- **Depression screening, substance use disorder/chemical dependency** when performed by the primary care physician
- **Nutritional counseling** including diabetes self-management, morbid obesity, and diet behavioral counseling

  Other nutritional counseling services may be covered when preauthorized by your primary care physician and BCN.

  

  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

- **Aspirin therapy counseling** for the prevention of cardiovascular disease
- **Tobacco use** and tobacco caused disease counseling

  

  Deductible (cost sharing) will apply to non-routine diagnostic procedures.

Any member cost sharing for office visits will still apply with the following restrictions:

- If a recommended preventive care service or early detection service is billed separately from the office visit, then you will be responsible for the office visit cost sharing, but there will be no cost sharing for the preventive care service;

Preventive and Early Detection Services (continued)

Member cost sharing for office visits will still apply with the following restrictions: (continued)

- If a recommended preventive care service or early detection service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of the preventive care service, you will have no cost sharing for the office visit; and

- If a recommended preventive care service or early detection service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of the preventive care service, you will be responsible for payment of any cost sharing for the office visit.

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

8.4 Inpatient Hospital (Facility) Services

We cover inpatient hospital (facility) and professional services in full after deductible 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, special diets
- Operating and other surgical treatment rooms, delivery room, and special care units
- Anesthesia, laboratory, radiology, and pathology services
- Chemotherapy, inhalation therapy and dialysis
- Physical, speech language and occupational therapy
- Long-term acute care
- Other inpatient services and supplies necessary for the treatment of the member
- Maternity care and all related services when provided by the participating attending physician or participating certified nurse midwife including home delivery. The participating certified nurse midwife must be overseen by a participating OB/GYN.

  Under federal law, the birth 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.

Maternity Care (continued)

Maternity care includes coverage of the birth parent'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 birth parent'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

  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 birth parent's attending physician
  - Routine care during the newborn's eligible hospital stay

  

  If the newborn is not covered under a BCN contract, they may qualify for coverage under the birth parent's maternity care benefit for the period of 48 or 96 hours.

- Certain other inpatient hospital services may have separate requirements. Your cost sharing is different. (See, for example, coverage for infertility, treatment of TMJ, weight reduction procedures and any attached riders.)

See Inpatient Professional Services subsection.

8.5 Outpatient Services

We cover outpatient services when medically necessary and preauthorized by your treating physician and BCN.

We cover outpatient services in the following places:

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

Outpatient services include but are not limited to:

- Facility and professional (physician) services
- Surgical treatment
- Anesthesia, laboratory, radiology and pathology services
- Chemotherapy, inhalation therapy, radiation therapy and dialysis
- Physical, speech language and occupational therapy - see Outpatient Therapy Services
- Injections (for allergy) - see Medical Professional Physician Services
- Professional services - see Medical Professional Physician Services
- Durable medical equipment and supplies - see Durable Medical Equipment
- Diabetic supplies and equipment - see Diabetic Supplies and Equipment
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics
- Other medically necessary outpatient services and supplies
- Preventive lab and radiology services are covered in full; deductible does not apply

Certain outpatient services have separate requirements. Your cost sharing is also different. (See, for example, coverage for infertility; treatment of TMJ, and weight reduction procedures and any attached riders.)

8.6 Emergency and Urgent Care

Definitions

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

Emergency Services
Services to treat a medical emergency as described above.

Medical Emergency
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 behavior 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 probably that no material deterioration of a condition is likely, within reasonable probability, to result from or occur during your transfer.

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

Coverage

Emergency services and urgent care services are covered after deductible up to the point of stabilization when they are medically necessary and needed either:

1) For immediate treatment of a condition that is a medical emergency as described above; or

2) If the primary care physician directs you to go to an emergency care facility.

In case of such medical emergency or accidental injury, you should seek treatment at once. We urge you, the hospital or someone acting for you to notify your primary care physician or BCN within 24 hours, or as soon as medically reasonable. Admission to the hospital after a Medical Emergency has been stabilized requires Authorization by BCN. However, a 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. 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 nonparticipating hospitals and independent free standing emergency departments, services rendered after the member is stabilized will continue to be emergency 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 nonparticipating 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 in-network deductible and in-network out-of-pocket maximum.

Observation stay resulting from emergency services is subject to emergency room cost sharing.

Follow-up care in an emergency room or urgent care facility - such as removal of stitches and dressings - is a covered benefit only when preauthorized by your primary care physician and by BCN. This applies even if the hospital emergency staff or physician instructed you to return for follow-up.

Admission to a Nonparticipating Hospital After Emergency Services

If you are hospitalized in a nonparticipating 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 nonparticipating hospital to continue receiving services. If you sign this form, all related non-emergency covered services will not be covered from the date when the form is signed.

Out-of-Area and Nonparticipating Provider Coverage

You are covered when traveling outside of the BCN service area for emergency services and urgent care services that meet the conditions described above. (See Section 9 for additional information.)

When services are rendered by a nonparticipating provider, we pay a rate based on the requirements of state and federal laws.

You are responsible for any cost sharing required under your rider. The rate we pay for Emergency Services may be less than the bill; you will not be required to pay the difference between what the Provider charges and what we pay. See Surprise Billing subsection for more information.

8.7 Ambulance

We cover ambulance services in full after deductible.

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

Locations: We pay for ground ambulance to take a member to a covered destination. A destination may include:

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

Locations: We pay for air ambulance to take a member to a covered destination. A destination may include:

- A hospital
- Another covered facility, with BCN prior authorization

In every case, the following conditions must be met:

- The service must be medically necessary. Any other means of transport would endanger the member's health. Ambulance services are medically necessary for:
  - Transporting a member to a hospital
  - Transferring a member from a hospital to another treatment location such as another hospital, other facilities, a medical clinic or the patient's home. (The attending physician must order the transfer.)
  - Ambulance providers to respond and treat the patient without transport

  

  Non-emergency ambulance services are covered when medically necessary and authorized by the patient's physician.

- We only pay for the transportation of the member and whatever care is required during transport. We do not pay for other services that might be billed with it.

- The service must be provided in a vehicle licensed as a ground or air ambulance, which is part of a licensed ambulance operation.

Ambulance (continued)

We pay for:

- A member to be taken to the nearest approved destination capable of providing the level of care necessary to treat the member's condition

  

  Transfer of the member between covered destinations must be prescribed by the attending physician and prior authorized by BCN.

  We also pay for ground and air ambulance services when:

  – The ambulance arrives at the scene but transport is not needed or is refused.
  – The ambulance arrives at the scene but the member has expired.

Air Ambulance

We pay for:

- Non-emergent air ambulance services between covered destinations

  These services must meet the following criteria:

  – The transfer must be preapproved and prescribed by the attending physician, and
  – The member will be taken to the nearest approved location capable of providing the level of care necessary to treat the member's condition

  

  The services must be approved before they occur. If they are not preapproved, they will be considered a noncovered benefit and you **may** have to pay their entire cost. It is important to make sure that your provider gets approval before you receive services.

Ambulance (continued)

Air ambulance services must also meet these requirements:

- No other means of transportation 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 taken to the nearest facility capable of treating the member's condition

If your air ambulance transportation does not meet the above requirements, the services may be eligible for review under case management. They may approve the services for transportation that positively impacts clinical outcomes, but not for a member's or family's convenience.

We do not pay for:

- 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.

Definition

Elective Abortion
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).

8.8 Reproductive Care and Family Planning

A) Genetic Testing

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

Covered in full after Deductible.

Genetic counseling and BRCA testing if appropriate for those 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 subsection.)

Exclusions include but are not limited to:

Genetic testing and counseling for non-members.

B) Voluntary Sterilization

We cover inpatient, outpatient, and office-based sterilization of male reproductive organs services.

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

Exclusions include but are not limited to:

Reversal of surgical sterilization of female and male reproductive organs.

C) Non-Elective Abortion

We cover non-elective abortion services **only** when meeting federally funded program guidelines, no matter the location. The 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

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

Your inpatient and outpatient benefit applies to non-elective abortion procedure including office consultations described in applicable riders associated with your plan.

Exclusions include but are not limited to:

- Any service related to elective abortions (unless covered by an elective abortion rider)
- Cases not identified above
- Abortions otherwise prohibited by law

D) Infertility

We cover diagnosis, counseling and planning services for treatment of the underlying cause of infertility when medically necessary and preauthorized by your primary care physician and BCN except as stated below and in Section 9.

Examples of covered services:

- Sperm count
- Endometrial biopsy
- Hysterosalpingography
- Diagnostic laparoscopy

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

Exclusions include but are not limited to:

- Harvesting
- Storage or manipulation of eggs and sperm
- Sperm washing
- Post-coital test
- Monitoring of ovarian response to ovulatory stimulants
- Ovarian wedge resection or ovarian drilling
- Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
- Any procedure done to enhance reproductive capacity and fertility
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- Artificial insemination, in-vitro fertilization (IVF) procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related services, and any other assisted reproduction procedure
- All services and fees related to surrogate parenting arrangements including, but not limited to, maternity and general 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 one year

We cover the following procedures for fertility preservation: (continued)

- Thawing of embryos, mature eggs and sperm within one year of the procurement
- Culture of eggs
- Ovarian transposition
- Embryo transfer to Member within one year from cryopreservation

Exclusions include but are not limited to:

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

8.9 Skilled Nursing Facility

We cover skilled nursing facility services in full after deductible for recovery from surgery, disease or injury. Skilled nursing care must be medically necessary and preauthorized by BCN.

Benefit Maximum

Up to a total benefit maximum of 45 days per calendar year.

Exclusions include but are not limited to:

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

8.10 Hospice Care

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

Hospice care in a participating licensed hospice facility, hospital or skilled nursing facility is covered. We also cover hospice care in the home.

We cover hospice care in full after deductible:

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

Short-term inpatient care in a licensed hospice facility is covered when skilled nursing services are required and cannot be provided in other settings.

Exclusions include but are not limited to:

- Housekeeping services
- Food, food supplements and home delivered meals
- Room and board at an extended care facility or hospice facility for purposes of delivering custodial care

8.11 Home Health Care Services

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

Home health care provides for members who are confined to their home as an alternative to long-term hospital care by offering coverage for care and services in the member's home.

Home health care must be:

- Medically necessary
- Provided by a participating home health care agency
- Provided by professionals employed by the agency and who participate with the agency

We cover home health care services in full after the deductible:

- Skilled nursing care provided by or supervised by a registered nurse employed by the home health care agency

- Intermittent physical, speech language or occupational therapy

  

  Outpatient therapy limits as defined in Outpatient Therapy Services subsection do not apply.

- Other health care services approved by BCN when they are performed in the member's home

Exclusions include but are not limited to:

- Housekeeping services
- Custodial care (See Section 9)

8.12 Home Infusion Therapy Services

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

Food Supplements

Supplemental feedings administered ***via tube***:

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

Supplemental feedings administered ***via 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 are covered in full after deductible when medically necessary and preauthorized by BCN.

8.13 Behavioral Health Services (Mental Health and Substance Use Disorder)

Mental Health Care

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 as medically necessary by BCN. For a list of services requiring preauthorization, contact Customer Service or visit https://bcbsm.com/priorauth. (Mental health emergency services are covered pursuant to Emergency and Urgent Care subsection.)

Medical services required during a mental health admission must be preauthorized separately by your primary care physician and BCN.

Definitions

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

Intensive Outpatient Mental Health
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 referral to other services.

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

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

Residential Mental Health Treatment
A state-licensed facility that allows for 24 hour domiciliary care and supervision for safety. That 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, decreasing life treating behaviors that cannot be managed in a lesser restrictive environment, improvement in activities of daily living 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

Coverage

Mental health care is covered in either an inpatient or outpatient setting. To obtain for 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. You do not need a referral from your primary care physician to get care.

See Section 9 for Exclusions and Limitations.

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 referral to other services.

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 pursuant to Emergency and Urgent Care Services subsection.)

Medical inpatient services required during a substance use disorder admission must be authorized separately by your primary care physician and BCN.

Definitions

Detoxification ("Detox")
Medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detox can occur in an inpatient, outpatient or residential setting.

Domiciliary Partial
Refers to partial hospitalization combined with an unsupervised overnight stay component.

Residential Substance Use Disorder Treatment
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, counseling, detox, medical testing, diagnostic evaluation, and referral to other services. Residential substance use disorder treatment is sometimes also referred to as intermediate care. Residential substance use disorder is not considered inpatient acute medical/surgical care in a hospital.

Intensive Outpatient Substance Use Disorder Treatment
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 is not necessarily limited to individual, group and family counseling, medical testing, diagnostic and medication evaluation and referral to other services.

Intermediate Care
Substance use disorder services that have a residential (overnight) component. Intermediate care includes detox, domiciliary partial and residential (including "inpatient") services.

Outpatient Substance Use Disorder Treatment
Outpatient visits (individual, conjoint, family or group psychotherapy) for a member who is dependent on and/or abusing alcohol or drugs (or both). The visit may include counseling, detox, medical testing, diagnostic evaluation and referral for other services.

Partial Hospitalization
A comprehensive, acute-care program that consists of a minimum of 4 hours per day, 3 days a week. Partial hospitalization treatment may include, but is not necessarily limited to, psychiatric evaluation and management, counseling, medical testing, diagnostic evaluation and/or referral to 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. You do not need a referral from your primary care physician to get care.

See Section 9 for Exclusions and Limitations.

8.14 Autism Spectrum Disorders

Definitions

Applied Behavioral Analysis (ABA)
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")
An academic and/or hospital-based, interdisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. An interdisciplinary evaluation such as that available at an AAEC is necessary to obtain preauthorization for ABA.

Autism Spectrum Disorders ("ASD")
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.

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

Evaluation
Includes 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
Tutoring or other activities performed one-on-one with person diagnosed with ASD.

Benefits

Services for the diagnosis and treatment of ASD are covered when performed by a BCN approved participating provider and preauthorized by BCN.

Services for the treatment of ASD are covered as follows:

- Comprehensive treatment focused on managing and improving the symptoms directly related to a member's ASD.
- Services and treatment must be medically necessary, preauthorized and deemed safe and effective by BCN.

Benefits (continued)

- Therapeutic care including:
  - Occupational therapy, speech language therapy and physical therapy
  - Autism spectrum disorder servicers (including ABA) when performed by a participating LBA or other participating provider acting within their scope of practice
  - Outpatient mental health therapy
  - Genetic testing
  - Nutritional therapy

Coverage

ABA or line therapy services are subject to the cost sharing as defined in cost-sharing riders associated with your plan. If you have a deductible rider, you may be responsible for meeting the deductible prior to BCN paying for covered services. Refer to your deductible rider for covered services not applicable to the deductible. You are required to pay any copay at the time the service is rendered.

Behavioral health services are subject to the behavior health cost share as defined in this certificate and applicable rider(s).

Outpatient therapy services are subject to the cost sharing as defined in the attached cost-sharing rider. You are required to pay any copayment at the time the service of services. If you have a deductible, you are responsible for meeting the deductible prior to BCN paying for covered services.

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 language therapy or occupational therapy.

Benefit Limitations

Coverage is available subject to the following requirements:

- **Preauthorization** – Services must be approved for payment during BCN's preauthorization process. If preauthorization is not obtained, rendered services will not be covered and the member may be held responsible for payment for those services. Once the initial Preauthorization expires, a request for continued services will be authorized contingent on the Member demonstrating measurable improvement and therapeutic progress.
- **Providers** – All services to treat ASD must be performed by a BCN participating provider.
- **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 language specialist. Other preauthorization requirements may also apply. This interdisciplinary evaluation can be performed at an approved AAEC.

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 including, but not limited to, sensory integration therapy and chelation therapy.
- Treatment for conditions not covered under BCN medical policy.

8.15 Outpatient Therapy Services

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

- Medical rehabilitation – includes but not limited to cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Speech language therapy
- Chiropractic and osteopathic mechanical traction
- Biofeedback for treatment of medical diagnosis when medically/clinically necessary, as determined according to BCN medical policies

We cover short term outpatient therapy services in full after deductible when the following conditions are met:

- 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 in full after deductible when preauthorized by BCN as medically necessary.

Examples include but are not limited to:

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

Benefit Maximums

Rehabilitative

- Rehabilitative physical therapy/occupational therapy/mechanical traction/physical medicine services are limited to combined benefit maximum of 30 visits per calendar year.
- Rehabilitative speech language therapy services are limited to a benefit maximum of 30 visits per calendar year.
- Cardiac and pulmonary rehabilitation is limited to a combined benefit maximum of 30 visits per calendar year.

Outpatient Therapy Services (continued)

Benefit Maximums (continued)

Habilitative

- Habilitative physical therapy/occupational therapy/physical medicine/mechanical traction services are limited to combined benefit maximum of 30 visits per calendar year.
- Habilitative speech language therapy services are limited to a benefit maximum of 30 visits per calendar year.

General exclusions include but are not limited to:

- Cognitive therapy and retraining (neurological training and retraining)
- Services for conditions that are generally required to be provided through publicly supported programs, public agencies or schools
- Vocational rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return-to-work programs
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency
- Craniosacral therapy
- Prolotherapy
- Rehabilitation services obtained from non-health professionals, including massage therapists
- Strength training and exercise programs
- Sensory integration therapy

Additional exclusions for speech language therapy include but are not limited to:

- Sensory, behavioral, cognitive or attention disorders
- Treatment of stuttering or stammering
- Swallowing therapy for deviant swallow or tongue thrust
- Vocal cord abuse resulting from life-style activities or employment activities such as, but not limited to, cheerleading, coaching, singing. Voice therapy is, however, covered in the presence of vocal cord nodules, polyps or vocal cord paralysis.
- Summer speech program - treatment for children who would be eligible to receive speech language therapy through school or a public agency

8.16 Durable Medical Equipment

Durable medical equipment (DME) is:

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

Coverage

We cover rental or purchase of DME when limited to the basic equipment. Any supplies required to operate the equipment and special features must be considered medically necessary and preauthorized by BCN. Items must be obtained from a DME participating provider 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.

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
- Blood pressure monitor when a member has elevated blood pressure reading regardless of hypertension diagnosis

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

Limitations include but are not limited to:

- The equipment must be considered DME under your coverage and must be:
  - Appropriate for home use
  - Obtained from a BCN participating provider
  - Prescribed by your primary care physician or a participating provider
  - Preauthorized by BCN
- The equipment is the property of the DME provider. When it is no longer medically necessary, you may be required to return it
- Repair or replacement, fitting and adjusting of DME are covered only when needed as determined by BCN resulting from body growth, body change or normal use
- Repair of the item if it does not exceed the cost of replacement

Exclusions include but are not limited to:

- Deluxe equipment (such as motor-driven wheelchairs and beds, etc.) unless medically necessary for the member and/or required so the member can operate the equipment.

  

  If the deluxe item is requested when not medically necessary, the approved amount for the basic item may be applied toward the price of the deluxe item at the member's option. You are responsible for any costs over the approved amount designated by BCN for a deluxe item that may be 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, damage or damage that can be repaired
- Assistive technology and adaptive equipment such as computers, supine boards, prone standers and gait trainers
- Modifications to your home, living area, or motorized vehicles - This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, swimming pools and car seats
- All repairs and maintenance that result from misuse or abuse
- Any late fees or purchase fees if the rental equipment is not returned within the stipulated period of time

8.17 Diabetic Supplies, Equipment and Outpatient Diabetes Management Program (ODMP)

We pay for the following in full after deductible:

- Services and medical supplies to treat and control diabetes when prescribed by a physician or other professional provider licensed to prescribe it and obtained from a BCN participating provider.

  Services and supplies include:

  - Blood glucose monitors
  - Blood glucose monitors for the legally blind
  - Insulin pumps
  - Test strips for glucose monitors
  - Visual reading and urine test strips
  - Lancets
  - Spring-powered lancet devices
  - Syringes
  - Insulin
  - Medical supplies required for the use of an insulin pump
  - Nonexperimental drugs to control blood sugar
  - Medication prescribed by a podiatric physician, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
  - Diabetic specialty shoes

Diabetic supplies and equipment are limited to basic equipment. Special features must meet medical necessity criteria and may require prior authorization by BCN. Replacement of diabetic equipment is covered only when medically necessary.

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

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

- Diabetes self-management training conducted in a group setting, whenever practicable, if:

  - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
  - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
  - The provider of self-management training must be:

    - Certified to receive Medicare or Medicaid reimbursement or
    - Certified by the Michigan Department of Community Health.

Exclusions include but are not limited to:

- Replacement due to loss, theft or damage or damage that can be repaired
- Deluxe equipment unless medically necessary for the member. 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

8.18 Prosthetics and Orthotics

Definitions

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

Prosthetic devices can be either:

- **External:** Devices such as an artificial leg, artificial arm or the initial set of prescription lenses for replacement of an organic lens of the eye following medically necessary eye surgery (e.g., cataract surgery)
- **Internal Implantable Prosthetic Devices:** Devices surgically attached or implanted during a preauthorized surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, implanted lens immediately following preauthorized surgery for replacement of an organic lens of the eye (e.g., cataract surgery) are considered internal devices

Orthotics
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 when preauthorized by BCN and obtained from a participating provider. Medically necessary special features are covered if prescribed by the treating physician, preauthorized by BCN and obtained from a participating provider or a participating facility upon discharge.

We cover:

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

Prosthetics and Orthotics (continued)

We cover: (continued)

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.

Limitations

The item must meet the coverage definition of a prosthetic or orthotic device and the following criteria:

- Preauthorized by BCN
- Obtained from a BCN-approved provider that has obtained accreditation from a Medicare-deemed accrediting organization
- Prescribed by your primary care physician or a participating provider
- Limited to the basic items - If a deluxe item is requested, the approved amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the approved amount designated by BCN for the different type of item that is prescribed
- Any special features 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 foot orthotics
- Shoe inserts that are not attached to leg brace
- Over the counter supplies and disposable supplies such as compression stocking
- Devices that are experimental and research in nature
- Items for the convenience of the member or care giver
- Repair or replacement due to loss, theft, damage or damage that cannot be repaired
- Duplicate appliances and devices

8.19 Organ and Tissue Transplants

We cover organ or body tissue transplant and all related services in full after deductible when:

- It is considered non-experimental in accordance with generally accepted medical practice
- It is medically necessary
- Preauthorized by BCN
- It is performed at a BCN-approved transplant facility

Your inpatient and outpatient cost sharing applies as defined in the riders attached to this certificate.

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

- 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.

Exclusions include but are not limited to:

- Community wide searches for a donor

8.20 Reconstructive Surgery

Definition

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

Reconstructive surgery may include:

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

Coverage

We cover reconstructive surgery in full after deductible when it is medically necessary and preauthorized by BCN.

A) Reduction Mammoplasty (breast reduction surgery) for members when it is medically necessary and preauthorized by BCN

B) Male Mastectomy for treatment of gynecomastia when it is medically necessary and preauthorized by BCN

8.21 Oral Surgery

We cover oral surgery and X-rays in full after deductible only when preauthorized by BCN for:

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw
- Oral surgery and dental services necessary for **immediate** repair of trauma to the jaw, natural teeth, cheeks, lips, tongue, roof and floor of the mouth

  

  "Immediate" means treatment within 72 hours of the injury. Any follow-up treatment performed after the first 72 hours post-injury is not covered
- Anesthesia covered in an outpatient facility setting when medically necessary and preauthorized by BCN
- Medically necessary surgery for removing tumors and cysts within the mouth

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

Exclusions include but not limited to:

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

See Section 9 for additional exclusions.

8.22 Temporomandibular Joint Syndrome (TMJ) Treatment

Definition

Temporomandibular Joint Syndrome (TMJ) Treatment
A condition of muscle tension and spasms related to the temporomandibular joint, facial and/or cervical muscles that may cause pain, loss of function and/or physiological impairment.

Coverage

We cover medical services and treatment for TMJ when medically necessary and preauthorized by BCN:

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

Dental Services are not covered.

Exclusions include but are not limited to:

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

8.23 Orthognathic Surgery

Definition

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

Coverage

We cover the services listed below in full after the deductible when medically necessary and preauthorized by BCN:

- Office consultation with specialist physician
- Cephalometric study and X-rays
- Orthognathic surgery
- Postoperative care
- Hospitalization – only when it is medically necessary to perform the surgery in a hospital setting

Exclusions include but are not limited to:

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

8.24 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

Benefit Maximum

Surgical treatment of obesity is limited to once per lifetime unless medically necessary as determined by BCN.

8.25 Prescription Drugs and Supplies

Definition

Medically Necessary Drug
A drug 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 member's condition and not mainly for the convenience of the member or prescriber.

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

Prescription drugs and supplies are covered only if a BCN participating 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 that are prescribed and received during a covered inpatient hospital stay as medical benefits.

B) Cancer Drug Therapy

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

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

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

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

Coordination of Benefits for Cancer Therapy Drugs: If you have BCN prescription drug rider or coverage through another plan, 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
- 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 approved 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 only if you a have a BCN prescription drug rider attached to this certificate.

Exclusions include but are not limited to:

- Drugs not approved by the U.S. Food and Drug Administration
- 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) Outpatient Prescription Drugs

We do not cover outpatient prescription drugs and supplies unless you have a BCN prescription drug rider attached to this certificate. (See Section 9)

8.26 Clinical Trials

Definition

Approved Clinical Trial
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
Any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted.

Qualified Individual
A member eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

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

Routine Patient Costs
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 were 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 after deductible when all of the following are met:

- BCN considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The treatment is covered under your certificate and associated 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 oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCN).

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

Limitations and exclusions include but are not limited to:

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

8.27 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 the clinical diagnosis of gender dysphoria. These services may include hormone treatment and/or gender affirming surgery, as well as counseling and behavioral health services. These services must be medically necessary to be payable by BCN. BCN will not pay for services that it considers to be cosmetic. BCN also will not pay for services that are experimental or investigational.

Coverage

We cover gender affirming services when determined to be medically necessary, preauthorized by BCN and performed by BCN participating providers. The provider must supply documentation supporting that you meet the BCN medical criteria and established guidelines.

Exclusions include but are not limited to:

- Gender affirming services that are considered cosmetic
- Experimental or investigational treatment

8.28 Collaborative Care Management

Collaborative Care Management also known as CoCare operates through a care team centered around the patient to manage medical and behavioral health conditions. The care team includes a primary care physician (PCP), behavioral health care manager (BHCM) and a consulting psychiatrist.

CoCare services are covered when they are performed by designated providers. Under CoCare, a care manager will coordinate your care.

Locations: We pay for professional services for CoCare in the following locations, subject to the conditions described below:

- An office
- A participating outpatient hospital
- A participating facility
- A member's home
- Other locations designated by BCBSM

We pay for:

- Telephone or face-to-face contact and group interventions
- Medication assessments to identify:
  - The appropriateness of a drug for your condition
  - The correct drug dosage
  - The right time to take the drug
  - The drug Interactions

Covered services are subject to change.

Eligibility

You are eligible to receive Collaborative Care Management if you have:

- Active BCN coverage
- A chronic medical condition along with a behavioral health condition
- Agreed to actively participate with CoCare
- A referral for care management services from your physician

Collaborative Care Management (continued)

Eligibility (continued)

Your physician will determine your eligibility and refer you to care managers based on factors, such as your:

- Diagnosis
- Admission status
- Clinical status

Termination of Collaborative Care Management

You may opt-out of CoCare at any time. BCN may also terminate CoCare services based on:

- Termination or cancellation of your BCN coverage
- Other factors

We do not pay for:

- Services performed by providers who are not designated as CoCare providers

For more information on CoCare services, contact BCN Customer Service.

8.29 Enhanced Condition Management Program (ECMP)

Your coverage includes the programs listed below. The services must be received from an approved BCN vendor. To see the available programs(s), go to the Health and Well-Being | My online account | bcbsm.com website or you may also contact BCN Customer Service. You may have one or all of the following conditions to qualify for these programs:

- Pre-diabetes
- Diabetes
- Hypertension

We pay for:

- Diabetes Prevention Program
  - Select services, equipment, and tools to reduce the risk of a Type 2 diabetes diagnosis
- Enhanced Diabetes Management Program
  - Select services, equipment, tools to manage Type 2 diabetes
- Cardiovascular Management Program
  - Select services, equipment, and tools to manage hypertension

Limitations:

You are not eligible for this program if:

- You received services from a nonapproved BCBSM vendor
- You do not meet the program eligibility guidelines
- Medicare is your primary payer

SECTION 9: Exclusions and Limitations

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

9.1 Unauthorized and Out-of-Network Services

Except for emergency care as specified in Section 8 and Chapter 2 – Important Information section, health, medical and hospital services are covered **only** when:

- Provided by a BCN participating provider
- Preauthorized by BCN for select services
- Determined to be medically necessary

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

9.2 Services Received While a Member

We will only pay for covered services you receive while you are a member, covered under this certificate, and attached riders. Once your coverage under this certificate ends, any attached riders to this certificate will automatically end without further action or notice by BCN.

A service is considered to be received on the date on which Services or supplies are provided to you. We can collect from you all costs for covered services that you receive and we pay for after your terminates, plus our cost of recovering those charges (including attorney's fees).

9.3 Services That Are Not Medically Necessary

Services that are not medically necessary are not covered, unless specified in this certificate. The Medical Director makes the final determination of medical necessity based upon BCN internal medical policies.

9.4 Non-Covered Services

We do not pay for the following:

- 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 consciousness using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation
- 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 coverage
  - Insurance
  - Travel (immunizations for purposes of travel or immigration are a covered benefit)
  - Licenses and marriage license applications
  - Legal proceedings such as parole, court and paternity requirements
  - School purposes, camp registrations, or sports physicals
  - Educational and behavioral evaluations performed at school
  - Completion or copying of forms or medical records, medical photography charges, interest on late payments, and charges for failure to keep scheduled appointments

Non-Covered Services (continued)

We do not pay for the following: (continued)

- 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 and transportation and/or lodging, except for covered ambulance services
- Autopsies
- Employment related counseling
- Modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities
- Fees incurred for collections, processing and storage of blood, cells, tissue, organs or other bodily parts in a family, private or public bank or other facility without immediate medical indication
- Testing to determine legal parentage
- Services performed by a provider with your same legal residence
- Services performed by a provider who is a family member
- Food, dietary supplements and metabolic foods
- Private duty nursing
- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
- Routine eye exams or hearing tests (unless they are related to illness, injury, or pregnancy)
- Services outside the scope of the practice of the servicing provider
- Late fees
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Psychoanalysis and psychotherapy that is not intended or likely to produce meaningful improvement
- 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
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a participating provider
- Gambling addiction treatment

Non-Covered Services (continued)

We do not pay for the following: (continued)

- Care, services, supplies or procedures that are cognitive in nature (such as memory enhancement, development or retraining)
- 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 consciousness using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation
- Treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services, including enrichment programs such as:
  - Dance therapy
  - Art therapy
  - Equine therapy
  - Ropes courses
  - Music therapy
  - Yoga and other movement therapies
  - Guided imagery
  - Consciousness raising
  - Socialization therapy
  - Social outings and education/preparatory courses or classes

We do not pay for the following: (continued)

9.5 Cosmetic Surgery

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

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

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

9.6 Prescription Drugs

We do not pay for the following:

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

However, you may have an outpatient prescription drug rider issued to you that allows coverage.

9.7 Military Care

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

9.8 Custodial Care

Custodial care is used to maintain your basic need for food, shelter, housekeeping services, clothing and help with activities of daily living.

We do not pay for custodial care.

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

9.9 Comfort Items

We do not pay for the following comfort or convenience items:

- Personal comfort
- 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 exam, or the preparation of court-related reports that do not meet health care coverage requirements.
- **We do not cover** court-ordered treatment for substance use disorder or behavior health condition except as specified in Sections 8.
- We shall not be liable for any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member being engaged in an illegal occupation.

9.11 Elective Procedures

We do not pay for:

- Reversal of a surgical sterilization
- Treatment for infertility including but not limited:
  - Artificial insemination
  - In vitro fertilization (IVF)procedures, such as GIFT – gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer and all related services
  - Any other assisted reproduction procedure

Elective Procedures (continued)

We Do Not Pay For (continued)

  - Fees to surrogate parent
  - Prescription drugs designed to achieve pregnancy
  - Harvest preservation and storage of eggs or sperm
- Genetic testing and counseling for non-members for any purpose

9.12 Maternity Services

We do not pay for:

- Services and supplies provided by a lay-midwife for home births
- All services provided to non-member surrogate parents
- Lamaze, parenting or other similar classes
- Services provided to the newborn if one of the following apply:

  - The newborn's birth parent is not covered under this certificate on the newborn's date of birth
  - The newborn is covered under any other health care benefit plan on their date of birth
  - The subscriber directs BCN not to cover the newborn's services
  - Services provided to the newborn that occur after the 48 or 96 hours defined under the birth parent's maternity care benefit

9.13 Dental Services

We do not pay for the following, including, but not limited to:

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

9.14 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 chapter describes the rules of your health care coverage.)
- Under any public health care, school, or public program supported totally or partly by State, Federal or local governmental funds except where BCN is made primary by law.

  The following are excluded to the extent permitted by law:

  – Services and supplies provided in a nonparticipating hospital owned and operated by any Federal, State or other governmental entity

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

9.15 Alternative Services

We do not pay for:

Alternative treatments are not used in standard Western medicine. An alternative treatment is not widely taught in medical schools.

Services we do not cover 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:

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

9.17 Hearing Aid Services

We do not pay for:

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

9.18 Out-of-Area Services/Inter-Plan Claims Processing

BCN only covers limited healthcare services outside of its Michigan service area. Non-emergency, non-urgent, and routine healthcare services such as lab tests, injections, and x-rays will not be covered outside of BCN's Michigan service area. However, emergency room services and urgent care services are covered.

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

Inter-Plan Program
Emergency and urgent care services received outside of Michigan are administered through the Blue Cross Blue Shield Association program. Under this program, the Blue Cross and/or Blue Shield plan located outside of Michigan is the Host Plan. When you access emergency and urgent care services outside of BCN's service area, the Host Plan will be responsible for contracting and handling all interactions with its participating providers.

In some instances, if you obtain care from providers that do not participate with the Host Plan, BCN will be responsible for processing those claims.

Out-of-Area Services/Inter-Plan Claims Processing (continued)

Member Liability Calculation

Unless subject to a fixed dollar copayment, your deductible, copayment, and coinsurance will be based on the lower of:

- The billed charges, or
- The Host Plan's negotiated price using:

  (1) A simple discount that reflects an actual price that the Host Plan pays to your provider;

  (2) Estimated price. An estimated price that considers special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges; or
  (3) Average price. An average price is a percentage of billed charges for covered services.

The price the Host Plan uses will be the final price that you are responsible for. There will be no pricing adjustment once that price has been determined.

The average or estimated pricing also include adjustments we may need to make to estimates of past pricing for transaction changes noted above. These adjustments will not affect the price we pay for your claim because they are not applied to claims already paid.

When out-of-area emergency room and urgent care visits are provided outside of the BCN service area by nonparticipating providers, the amount(s) you pay for such services are defined in your medical cost sharing rider.

Blue Cross Blue Shield Global® Core
If you are outside the United States, (the Commonwealth of Puerto Rico and the U.S. Virgin Islands which make up the Inter-Plan Program Service Area), you may be able to use Blue Cross Blue Shield Global® Core to assist you with accessing covered healthcare services. When you receive care from providers outside the **Inter-Plan** Program service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for emergency and urgent services.

- **Inpatient Services**
  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient hospital services, except for any cost sharing you may owe. The Blue Cross Blue Shield Global® Core contracting hospital will submit your claims to the service center to initiate claims processing.

  If you paid in full at the time of service, you must submit a claim to obtain reimbursement for covered emergency inpatient services.

Blue Cross Blue Shield Global® Core (continued)

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient providers located outside the **Inter-Plan Program** service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered emergency and urgent services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**
  When you pay for covered emergency and urgent services outside the **Inter-Plan Program** service Area, you must submit a claim to obtain reimbursement.

  For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. The claim form is available from us, the service center or online at https://www.bcbsglobalcore.com.

  If you need assistance with the claim submissions, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Exclusions and Limitations

- We do not cover non-emergency and non-urgent care services outside of the Blue Care Network (BCN) Service Area.

- Inter-Plan Program does not process claims for covered services from a BCN-contracted vendor or provider.

General Information

If you have a deductible, you must pay your deductible for covered services at the time you receive those services.

Your deductible, coinsurance and copayment requirements are based on your certificate and attached riders and remain the same regardless of which Host Blue processes your claim for services.

For more information about out-of-area services go to https://bcbsm.com/ or call Customer Service at the number shown on the back of your BCN ID card.

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 711 :TTY 877-469-2583 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。

ܙܘܗܪ̈ܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܚܬܫܡܫܝܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܒܕ ܗܘܝܐ ܦܪ̈ܝܐ ܩܕܡܝܟܘܢ ܕܠܐ ܐܓܪܐ. ܐܦ ܚܬܫܡܫܝܬ̈ܐ ܗܝܪ̈ܢܝܬܐ ܠܫܝܢܐ ܠܡܫܠܡܬܐ ܕܡܕܥܬ̈ܢܘܬܐ ܒܦܘܪܡܝ̈ܐ ܡܨܛܠܚܢܐ ܡܠܟܘܢ ܦܪ̈ܝܐ ܕܠܐ ܐܓܪܐ. ܡܩܪܘܢ ܥܠ ܡܢܝܢܐ 877-469-2583 TTY: 711 ܐܘ ܡܗܡܙܡܝܬܘܢ ܥܡ ܡܦܪܢܣܢܘܟܘܢ.

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 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

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/

INDEX

2

24/7 Virtual Visit iii

A

Accidental Injury 50
Acute Care or Service iii
Acute Illness iii
Adverse Benefit Determination 16
Applied Behavioral Analysis (ABA) 66
Approved Amount iii
Approved Autism Evaluation Center (AAEC) 66
Approved Clinical Trial 82
Assertive Community Treatment iii
Autism Spectrum Disorders (ASD) 66

B

Balance Billing iii
Benefit iii
Blue Care Network (BCN) iii

C

Calendar Year iii
Certificate iv
Certificate of Coverage iv
Chronic iv
Claim for Damages 11
Collaborative Care Management ..... iv, 86
Collateral Source Rule 11
Common Fund Doctrine 11
Continuity of Care iv
Contraceptive Counseling iv
Contract iv
Coordination of Benefits iv
Copay iv
Copayment iv
Cost Sharing v
Covered Services v
Custodial Care v

D

Deductible v
Dependent Child v
Detoxification 65
Domiciliary Partial 65

E

Elective Abortion vi
Emergency Medical Condition vi
Emergency Services 50
Emergency Treatment 88
Enrollment vi
Equitable Distribution Principles 12
Evaluation 66
External Prosthetics 74

F

Facility vi
Family Dependent vi
Federal Food and Drug Administration 38
First Priority Security Interest 11

G

Gender Dysphoria 85
Gender Reassignment Services 85
General Provisions vi
Grievance vi

H

Habilitative Services/Devices vii
HDHP vii
Health Savings Account vii
High Deductible Health Plan vii
Hospital vii
HSA vii

I

Injury iii
Inpatient vii
Inpatient Mental Health Service 63
Intensive Outpatient Mental Health 63
Intensive Outpatient Substance Use Disorder Treatment 65
Internal Prosthetic Devices 74

L

Lien 11
Life-Threatening Condition 83
Line Therapy 66
Long-Term Acute Care Hospital Services
Definition vii

M

Made Whole Doctrine 11
Medicaid Diabetes Treatment 73
Medical Director vii
Medical Emergency 51
Medical Necessity viii
Medically Appropriate viii
Medically Necessary viii
Medically Necessary Drug 80

Medicare Diabetes Treatment....73
Member....viii
Mental Health Provider....viii

N

Non-elective Abortion....ix
Nonparticipating....ix
Nonparticipating Provider....ix

O

Observation Care....ix
Online Visit....ix
Open Enrollment Period....x
Orthognathic Surgery....79
Orthotics....74
Outpatient Mental Health....63
Outpatient Substance Use Disorder Treatment....65

P

Partial Hospitalization Mental Health....63
Participating....x
Participating Provider....x
PCP....xi
PCP Referral....x
Physical Medicine....x
Plaintiff....12
Post-Service Grievance....16
PPACA....x
Preauthorization....x
Preauthorized Service....x
Premium....x
Pre-Service Grievance....16
Preventive Care....xi
Primary Care Physician....xi
Principally Supported Child....xi
Prior Authorization....x
Professional Services....xi
Prosthetics....74

Q

Qualified Individual....83

R

Referral....xii
Referral Physician....xii
Rehabilitation Services....xii
Rescission....xii
Residential Mental Health....64
Residential Substance Use Disorder Treatment....65
Respite Care....xii
Rider....xii
Routine....xii
Routine Patient Costs....83

S

Service Area....xii
Services....xii
Skilled Care....xiii
Skilled Nursing Facility....xiii
Stabilization....51
Subscriber....xiii
Surprise Billing....xiii

T

Telemedicine....xiii
TMJ....78

U

Urgent Care Center....xiii
Urgent Care Services....51

Y

Your Benefits....xiii