Welcome to Blue Care Network

University of Michigan Student Health Plan

with your Certificate of Coverage and riders

Confidence comes with every card.

bcbsm.com
Quick Reference

**IMPORTANT OR FREQUENTLY USED PHONE NUMBERS**

**Customer Service:** 1-800-662-6667, TTY: 711
(8 a.m. to 5:30 p.m. Monday through Friday)
Talk to a representative about your plan or benefits. We’re available during and after normal business hours, and we offer language assistance. Our staff identify themselves by name, title and organization when receiving and returning calls.

**Behavioral Health Services:** 1-800-482-5982
Talk to a behavioral health manager in an emergency about issues that cause emotional or mental distress, including substance use disorder issues. For more information, see Section 2, "How to Use Your Benefits."

**Care while you travel:** 1-800-810-BLUE (2583)
Find a doctor, urgent care facility or hospital that participates in BlueCard®, our care program when you’re away from home.

**24-hour Nurse Advice Line:** 1-855-624-5214
Get answers to health care questions any time, anywhere with support from registered nurses.

**Tobacco Cessation Coaching, powered by WebMD®:** 1-855-326-5102
Call to sign up for this telephone-based program to help you quit tobacco.

*WebMD Health Services is an independent company supporting Blue Care Network by providing health and well-being services.*
Dear UM Student Domestic:

Welcome to Blue Care Network!

We know that health care can seem complicated. That’s why we’re committed to helping you understand your coverage and achieve your wellness goals. This handbook outlines your benefits and explains how your plan works, including:

- What to do first now that you’re a member
- What to do if you get sick or injured
- What you’ll pay for certain services
- The resources we offer to help you stay healthy

We're here to help, so if you have questions about your coverage, call Customer Service or register at bcbsm.com for 24-hour access to your account.

Thank you for your membership. You’ve made the right choice.

Sincerely,

KATHRYN G. LEVINE, PRESIDENT AND CEO
# Contents

1. **Getting Started**.............................. 01
   - **What you need to know**
     - Register for an online member account
     - View or change your primary care physician
     - Make an appointment with your doctor
     - Understand your options for care
     - How you share costs
     - BCN authorization
     - In network vs. out of network
     - If your doctor isn’t in BCN’s network
     - Update your records
     - Coordination of benefits
     - Advance directives: Make your wishes known

2. **How to Use Your Benefits**............ 06
   - **The information you need when you get care**
     - When you need medical care
     - Your benefits when you travel
     - Blue Cross Online Visits℠
     - Lab services
     - Pain management
     - Medical supplies and equipment
     - Behavioral health coverage
     - Some services aren’t covered
     - Special care for women

3. **Your Drug Benefit**....................... 13
   - **What’s covered, how to save and how to fill prescriptions**
     - Your prescription drug coverage
     - Your drug list
     - How tiers work
     - Keeping down costs with generic drugs
     - Some drugs don’t have a copay
     - Some drugs need approval
     - Filling a prescription
     - Some drugs and medical supplies aren’t covered

4. **Your Benefits at a Glance**............. 18
   - **A quick guide to what you’ll pay for services**
     - Understanding your benefits
     - Commonly used benefits

5. **Information For You**.................... 25
   - **Disclosures and documents for your reference**
     - BCN: Part of the Blue Cross family
     - Your rights and responsibilities
     - Grievance process
     - Quality assurance
     - How we determine new health services
     - Privacy practices

6. **Your Benefit Documents**............. 36
   - **Your Certificate of Coverage** and applicable riders
Thank you for being part of Blue Care Network.

We want to help you understand your medical health care costs. And this card is a convenient way to help you keep track. Detach it and keep it with your health plan ID card so you’ll know what you may have to pay when you receive certain covered medical services*. Consider the card another helpful tool to use along with your Member Handbook, where you’ll find these sections:

• "Getting Started" with information you need about your health care plan
• "How to Use Your Benefits" so you know how to get care when you need it
• "Your Benefits at a Glance" for a quick guide to what you’ll pay for services

For the most detailed and up-to-date information about your plan, log in to your account at bcbsm.com to see the legal documents that describe your coverage.

<table>
<thead>
<tr>
<th>Your costs</th>
<th>Printed on: 07/24/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP visit: $20 copay</td>
<td></td>
</tr>
<tr>
<td>Specialist visit: $20 copay</td>
<td></td>
</tr>
<tr>
<td>Urgent care: $20 copay after deductible</td>
<td></td>
</tr>
<tr>
<td>ER: $75 copay</td>
<td></td>
</tr>
<tr>
<td>Deductible: $100 per member/$200 per family</td>
<td></td>
</tr>
<tr>
<td>Coinsurance max: None</td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket max: $3,500 per member/$7,000 per family</td>
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</tbody>
</table>

*Other costs may apply for primary care physician and specialist visits if additional services are performed in the office.
This information serves as a quick reference of what you may pay for certain health care services. These amounts may vary depending upon the actual services performed during your visit. Refer to your account at bcbsm.com for a complete description of your benefits and applicable cost-sharing amounts. There, you’ll find the legal documents that describe your coverage. For questions, call the customer service number on the back of your health plan ID card.

For your convenience, write in your primary care physician’s name and phone number.

____________________________   _______________________
(Name) (Phone)
1. Getting Started

1. REGISTER FOR AN ONLINE MEMBER ACCOUNT
With a secure member account at [bcbsm.com](http://bcbsm.com), you can manage your health care plan, including changing your primary care physician. You can also see a summary of your benefits, recent claims and out-of-pocket costs, such as your copayments.

- Get started by going to [bcbsm.com/register](http://bcbsm.com/register) or downloading the Blue Cross ® app. Search "BCBSM" in the Apple App Store® or Google Play™.

- Once you have an online account, you'll have access to MiBlue Virtual Assistant — an interactive, automated, chat feature that provides immediate answers to your coverage questions.

2. VIEW OR CHANGE YOUR PRIMARY CARE PHYSICIAN
When you enroll with Blue Care Network and are a student on the Ann Arbor campus, you'll be assigned a University Health Services primary care physician who's at the Ann Arbor campus. If you’re a student at the Dearborn or Flint campus, you’ll be assigned a BCN-contracted PCP in your area.

- To view or change your PCP, log in to your member account at [bcbsm.com](http://bcbsm.com) using any device. Click Doctors & Hospitals in the navigation menu, then click Primary Care Physicians from the drop-down menu. Once you change your PCP online, you'll receive an email confirming the change.

- Or call Customer Service at 1-800-662-6667, and we'll help you choose.

*Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.

**Google Play and the Google Play logo are trademarks of Google Inc.**
1. GETTING STARTED

3. MAKE AN APPOINTMENT WITH YOUR DOCTOR
Get to know your primary care physician — make an appointment for your annual wellness visit or to discuss a medical condition. Your doctor can also write and renew your prescriptions.

4. UNDERSTAND YOUR OPTIONS FOR CARE
You can self-refer to any doctor, but you’ll pay more out of pocket if you’re seeking care from a doctor who’s not in the BCN network. You and the doctor treating you are responsible for getting approval from BCN before services are covered. To get approval, your doctor will need to call the authorization number on the back of your member ID card.

Covered services
These are health care services, prescription drugs and equipment or supplies that are medically necessary, meet requirements and are paid in full or in part by your plan.
How you may share costs with us

Your plan dictates whether you have to pay out of pocket when you receive health services. See explanations below. For specifics about your plan, log in to your account at bcbsm.com. Click My Coverage in the navigation menu, then Medical and then What’s Covered.

- **Beginning of your plan year**
  - Depending on your plan, BCN pays for certain preventive care and wellness costs throughout the year at no cost to you.
  - You pay copayments for certain covered services, like PCP office visits and urgent care.
  - You pay for other medical costs until you meet your deductible, if your plan includes a deductible.

- **Once you've met your deductible (if applicable)**
  - You continue to pay copayments and coinsurance until the total you've paid for copayments, coinsurance and deductibles meets your out-of-pocket maximum.
  - If there's more than one person on your plan, you may have to meet a family, as well as an individual, out-of-pocket maximum.

- **Once you've reached the out-of-pocket maximum(s)**
  - BCN pays for all other covered services. You don't owe a thing. (Please note your plan may not have an out-of-pocket maximum.)

- **At the end of the plan year**
  - Your deductible and out-of-pocket maximum reset for the next year.

**Copayment (or copay)**
A fixed dollar amount you pay each time you get certain types of care (for example, $25 for a visit to your PCP or $50 for an urgent care visit).

**Coinsurance**
Your share of the costs of a covered service, calculated as a percentage (for example, you pay 20 percent of the BCN approved amount, and BCN pays 80 percent).

**Deductible**
The amount you must pay for most health care services before BCN begins to pay. The deductible may not apply to all services.

**Out-of-pocket maximum**
The most you may have to pay for covered health care services during the year. The out-of-pocket maximum includes your deductible, copays and coinsurance.
1. GETTING STARTED

BCN authorization

Sometimes, special authorization is required for medical services such as hospital care, elective surgeries and specialty drugs. This means your doctor must contact us, and we must approve care before you receive it, or you may be responsible for the cost of the service.

In-network vs. out-of-network care

A network is a group of providers (doctors, hospitals and vendors) that have contracted with BCN to provide health care services. Note: You’re

<table>
<thead>
<tr>
<th>IN NETWORK</th>
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<tbody>
<tr>
<td><strong>In-network providers</strong> are part of your plan’s network. Be sure that your PCP refers you to in-network providers so your care is covered at the lowest cost.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-network providers</strong> aren’t part of the network. You can choose to get care from an out-of-network provider, but you’ll pay more. Certain out-of-network services must also be authorized by BCN before you receive them. Otherwise, you’ll be responsible for the entire cost of the service.</td>
</tr>
</tbody>
</table>

If your doctor isn't in BCN's network

To continue care with a doctor who’s not in BCN’s network, one of these situations **must** apply to you. If not, out-of-network cost sharing will apply:

- You’re receiving an ongoing course of treatment and changing doctors would interfere with recovery (care may continue through the current course of treatment — up to 90 days).
- You’re in the second or third trimester of pregnancy (care may continue through delivery).
- You have a terminal illness (care may continue for the remainder of your life).

This continuity of care may also apply when your doctor leaves the BCN network. Authorization from BCN is required.

📞 To ask for continuity of care, call Customer Service at 1-800-662-6667.
1. GETTING STARTED

Update your records / LIFE EVENTS

Report address changes or life events to the University within 31 days of when they happen:

• Birth of a child
• Adoption or legal guardianship
• Marriage
• Divorce
• Death
• Name change
• New address or phone number
• Medicare eligibility

Coordination of benefits

WHEN YOU HAVE MORE THAN ONE PLAN

Coordination of benefits means lower costs and the best possible benefits. Tell us if you or anyone in your family has other medical or prescription drug coverage, such as:

• Spousal coverage: You have additional medical or prescription coverage through your spouse’s employer.
• Medicare: You or someone in your family has Medicare coverage.
• Dependent coverage: Your children have coverage with BCN and also through their other parent’s plan.
• Accident coverage: You have an automobile or workplace injury and another insurer may be responsible for coverage.

To update your information online, log in as a member at bcbsm.com and click Account Settings.

Advance directives / MAKE YOUR WISHES KNOWN

If you were to become severely injured or too ill to make health care decisions on your own, who do you want to be in charge? Advance directives are legal documents that state your wishes.

Types of advance directives are:

• Durable power of attorney for health care — allows you to name an individual to make health care decisions for you when you are unable to do so.
• Do not resuscitate order — tells providers that you don’t wish to receive CPR if your breathing or your heart stops.

Download the forms from bcbsm.com. Type “advance directive” into the search box.

Call Customer Service at 1-800-662-6667 to get the forms by mail.

Michigan doesn’t recognize living wills.
# 2. How to Use Your Benefits

Find out how to get care, including routine office visits, specialty care and medical services.

## When you need medical care

This chart tells you what to do to get care. **You pay the least when you call your BCN doctor first** for all services from a routine checkup to an injury or symptoms that need prompt attention (with the exception of emergency care).

### GUIDE TO GETTING MEDICAL CARE

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Description</th>
<th>What you need to do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regular and routine care appointments (routine, primary and specialty care)</strong>&lt;br&gt;Get care: Within 30 business days</td>
<td>A health history and exam. Includes screenings and immunizations as required. For women, this includes your annual gynecology exam. Other preventive care</td>
<td>Call well in advance. Bring names of all prescriptions and over-the-counter medications you take. Bring immunization records if you have them. Make a list of questions to ask your doctor.</td>
</tr>
<tr>
<td><strong>Urgent care</strong>&lt;br&gt;Get care: Within 2 days</td>
<td>Sudden but not life-threatening conditions, such as fevers greater than 101 degrees lasting for more than 24 hours, vomiting that persists, mild diarrhea, or a new skin rash.</td>
<td>Call your PCP. Your physician or an on-call doctor will provide care or direct you to an urgent care center near you. You can also locate an urgent care center near you at bcbsm.com/find-a-doctor.</td>
</tr>
<tr>
<td><strong>Emergency care</strong>&lt;br&gt;Get care: Immediately</td>
<td>A condition that causes symptoms severe enough that someone with average health knowledge would believe that immediate medical attention is needed.</td>
<td>Seek help at the nearest emergency room or call 911. Contact your PCP within 24 hours.</td>
</tr>
<tr>
<td><strong>Hospital care</strong>&lt;br&gt;Get care: As needed</td>
<td>Conditions that require inpatient care.</td>
<td>Your PCP will arrange the hospital care you need and direct the care of any specialists who will see you there.</td>
</tr>
</tbody>
</table>
2. HOW TO USE YOUR BENEFITS

Your benefits when you travel

Doctors and hospitals that contract with Blue Cross and Blue Shield plans nationwide participate in BlueCard, our care program when you’re away from home.

💡 You can find BlueCard providers by using the Blue National Doctor & Hospital Finder at bcbsm.com.

📞 Learn more about the BlueCard program by calling Customer Service at 1-800-662-6667. You can also read the BlueCard disclosure in this book. See "Information About Us."

PHARMACY COVERAGE

You can fill prescriptions at any Blue Cross participating pharmacy when you travel. Your health care ID card is accepted at thousands of pharmacies nationwide, including most major chains.

EMERGENCY CARE

You’re always covered for emergency care — in Michigan, across the country and around the world. Just show your health care ID card. When traveling outside the United States, you may be required to pay for services and then seek reimbursement. To speed reimbursement, bring back an itemized bill or prescription invoice and any medical records you can get.

💡 Download the reimbursement form at bcbsm.com/billform.

📞 Or call Customer Service at 1-800-662-6667 for the form.

MEDICAL SUPPLIES AND EQUIPMENT

If you need durable medical equipment while traveling, call our partner, Northwood, Inc.*

📞 Call Northwood, Inc. at 1-800-667-8496.

If you need diabetic supplies while traveling, call our partner, J&B Medical Supply Company.**

📞 For more information, call J&B Customer Service at 1-888-896-6233.

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*Northwood is an independent company that provides durable medical equipment for Blue Care Network of Michigan.

**J&B Medical Supply Company is an independent company that provides diabetic materials for Blue Care Network of Michigan.
## 2. HOW TO USE YOUR BENEFITS

### GUIDE TO YOUR BENEFITS WHEN YOU TRAVEL

<table>
<thead>
<tr>
<th>Where you are</th>
<th>Type of care</th>
<th>What you need to do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Michigan</strong></td>
<td><strong>Emergency care</strong></td>
<td>Call 911 or go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td></td>
<td><em>The symptoms are severe enough that someone with average health knowledge believes that immediate medical attention is needed.</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>Go to the nearest urgent care center. To locate an urgent care center, call Customer Service or visit bcbsm.com/find-a-doctor.</td>
</tr>
<tr>
<td></td>
<td><em>The condition requires a medical evaluation within 48 hours.</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Nonurgent care</strong></td>
<td>You're covered in-network at any BCN provider in Michigan. To find a provider near you, call BCN's customer service or find one at bcbsm.com/find-a-doctor.</td>
</tr>
<tr>
<td><strong>In the United States</strong></td>
<td><strong>Emergency care</strong></td>
<td>Call 911 or go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td>but outside Michigan</td>
<td><strong>Urgent care</strong></td>
<td>Go to the nearest urgent care center. To locate an urgent care center, call BlueCard® at 1-800-810-BLUE (2583).</td>
</tr>
<tr>
<td></td>
<td><strong>Routine care</strong></td>
<td>Call Customer Service for details about your health benefits and required authorizations. Call BlueCard® at 1-800-810-BLUE (2583) to find a physician at your destination.</td>
</tr>
<tr>
<td></td>
<td><em>To treat or monitor a chronic condition or illness</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other services</strong></td>
<td>Call Customer Service for details about your health benefits and to determine which services require authorization.</td>
</tr>
<tr>
<td></td>
<td><em>Such as elective surgeries, hospitalizations, mental health or substance use disorder services</em></td>
<td></td>
</tr>
<tr>
<td><strong>Outside the United States</strong></td>
<td><strong>Emergency care</strong></td>
<td>Go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td></td>
<td><em>You may be required to pay for services and then seek reimbursement. Be sure to get an itemized bill and medical records to speed reimbursement.</em></td>
<td></td>
</tr>
</tbody>
</table>

- Download the reimbursement form at bcbsm.com/billform.
- Or call Customer Service at 1-800-662-6667 for the form.

*If your coverage includes BlueCard®, a program of the Blue Cross and Blue Cross Shield Association, you have nationwide access to Blue plan physicians and hospitals. Learn more about the BlueCard program by reading the disclosure document online at bcbsm.com/bluecarddisclosure, or call Customer Service at 1-800-662-6667 to have a copy sent to you.*
2. HOW TO USE YOUR BENEFITS

Blue Cross Online Visits℠

When you use Blue Cross Online Visits*, you’ll have access to online medical and behavioral health services anywhere in the United States. You and your covered family members can see and talk to:

- A doctor for minor illnesses such as a cold, flu or sore throat when your primary care physician isn’t available. Medical visits are available 24/7.

- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief. Behavioral health visits are available by appointment only.

HOW TO GET STARTED

Here’s how to use online visits:

- **Mobile:** Download the BCBSM Online Visits℠ app.
- **Web:** Visit bcbsonlinevisits.com.
- **Phone:** Call 1-844-606-1608.

No service key is required.

If you’re new to online visits, sign up and add your Blue Care Network health plan information.

For medical services, an online visit is based on your office visit cost share, or the amount selected in your plan documents. Costs for behavioral health services vary depending on the type of provider and service received. You’ll be charged the appropriate cost share for the service using your existing outpatient behavioral health benefits. Before your online visit, you’ll be prompted to enter your payment information.

*Online medical care doesn’t replace primary care physician relationships.*
2. HOW TO USE YOUR BENEFITS

Lab services

BCN contracts with Joint Venture Hospital Laboratories* to provide clinical laboratory services throughout Michigan. This gives you access to more than 80 hospitals and 200 service centers that provide 24-hour access and a full range of laboratory services.

📞 For information about lab services near you, call 1-800-445-4979.

Pain management

We provide coverage for certain medically necessary treatments to manage pain associated with a condition, because we consider pain management services an integral part of a complete disease treatment plan. Your doctor will coordinate the care you need.

Medical supplies and equipment

Your PCP may order durable medical equipment, such as a wheelchair or oxygen tank, to maintain your quality of life.

Your doctor will write a prescription. BCN only covers basic equipment that you can use at home. If the equipment you want has special features that aren’t medically necessary or are considered a luxury, you can choose to pay the cost difference between the basic item and the one with special features.

When you purchase medical equipment, you might have an out-of-pocket cost.

Northwood Inc. partners with BCN to provide durable medical equipment as well as prosthetic and orthotic appliances for members.

📞 To locate a Northwood provider near you, call Northwood at 1-800-667-8496 from 8:30 a.m. to 5 p.m. Monday through Friday. On-call associates are available after business hours.

J&B Medical Supply Company partners with BCN to provide diabetic materials, including insulin pumps and blood glucose meters.

📞 For more information, call J&B Customer Service at 1-888-896-6233.
2. HOW TO USE YOUR BENEFITS

Behavioral health coverage

All BCN members are covered for behavioral health, including mental health and substance use disorder. Also covered are other types of conditions that cause emotional or mental distress such as depression.

Behavioral health care managers are available 24 hours a day, seven days a week for emergencies at 1-800-482-5982 (TTY users call 711).

GUIDE TO GETTING BEHAVIORAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Description</th>
<th>What you need to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine care</td>
<td>Where no danger is detected and your ability to cope is not at risk.</td>
<td>Tell the behavioral care manager of any special needs to ensure appropriate referral.</td>
</tr>
<tr>
<td>Get care:</td>
<td></td>
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<tr>
<td>Within 10 days for a first visit</td>
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<tr>
<td>and 30 business days for</td>
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<tr>
<td>subsequent visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Conditions that are not life-threatening, but face-to-face contact is necessary</td>
<td>Call the mental health help number on the back of your BCN ID card.</td>
</tr>
<tr>
<td>Get care:</td>
<td>within a short period of time.</td>
<td></td>
</tr>
<tr>
<td>Within 48 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care for conditions</td>
<td>Conditions that require rapid intervention to prevent deterioration of your</td>
<td>Call the mental health help number on the back of your BCN ID card.</td>
</tr>
<tr>
<td>that are not life-threatening</td>
<td>state of mind, which left untreated, could jeopardize your safety.</td>
<td></td>
</tr>
<tr>
<td>Get care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 6 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care for life</td>
<td>A condition that requires immediate intervention to prevent death or serious</td>
<td>Seek help at the nearest emergency room, or call 911. After the emergency, contact</td>
</tr>
<tr>
<td>threatening conditions</td>
<td>harm to you or others.</td>
<td>your PCP within 24 hours.</td>
</tr>
<tr>
<td>Get care:</td>
<td></td>
<td></td>
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<tr>
<td>Immediately</td>
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</tbody>
</table>

Some services aren’t covered

Here are a few examples of services your medical plan doesn’t cover:

- Services obtained without following BCN procedures
- Cosmetic services or supplies
- Custodial care
- Experimental or investigational treatment
- Personal convenience items
- Rest cures
- Acupuncture
- Routine exams related to employment, insurance licensing, a court order or travel
- Self-help programs
Special care for women

We comply with all federal laws relating to the care of female members. These include:

BREAST RECONSTRUCTION FOLLOWING A MASTECTOMY

Our health coverage complies with the Women’s Health and Cancer Rights Act of 1998. It includes the following important protection for breast cancer patients who elect breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed for treatment of cancer
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and other care to alleviate physical complications of all stages of a mastectomy

HOSPITAL STAYS FOR CHILDBIRTH

The Newborns’ and Mothers’ Health Protection Act of 1996 prohibits health plans from restricting hospital stays for childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

A physician or other health provider doesn’t need to obtain authorization for prescribing a hospital stay up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician or certified nurse midwife, in consultation with the mother, may discharge the mother or newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.
3. Your Drug Benefit

Get to know your prescription drug benefit with information on coverage and how to fill prescriptions.

Your prescription drug coverage

We make every effort to provide the best value for your dollar, and your drug benefit reflects this. To see your drug benefit, which includes your coinsurance and copay amounts for prescriptions, you’ll need to view your prescription drug rider.

To view your drug rider, log in to your account at bcbsm.com. Click My Coverage in the navigation menu. Click Medical in the drop down menu. Click Plan Documents and scroll down to the Certificates and Riders section. If you're using the Blue Cross mobile app, log in to your account. Tap My Coverage, then Medical, then What's Covered, and scroll down the page.

Your drug list

The Custom Select Drug List shows the medications that may be covered under your drug benefit. These medications were selected by a team of doctors, pharmacists and other health care experts for their effectiveness, safety and value.

For the most current Custom Select Drug List of covered medications and requirements, visit bcbsm.com/BCNdruglists.

Download our Mobile App

With an Apple iPhone® or Android™ smartphone, you can use the BCBSM mobile app to research drug prices, see what your plan covers and view and share your virtual ID card. The mobile app connects you securely with the health plan info on your bcbsm.com account when you need it.
3. YOUR DRUG BENEFIT

How tiers work

Your drug list is organized by tiers, with the most cost-effective drugs in the lower tiers.

<table>
<thead>
<tr>
<th>TIER 1 • Lowest copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay the lowest copay for generic and certain brand-name medications.</td>
</tr>
</tbody>
</table>

- **TIER 1A • Lower generic copay**
  - These generic drugs are used to treat chronic diseases like high blood pressure, high cholesterol, diabetes, heart disease and depression.

- **TIER 1B • Higher generic copay**
  - Includes generic medications that don’t fall into Tier 1A.

<table>
<thead>
<tr>
<th>TIER 2 • Preferred brand copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>This tier includes brand-name drugs that don’t have a generic equivalent. These drugs are generally more expensive than generic medications.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIER 3 • Nonpreferred brand copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>This tier has a higher copay than Tier-1 or Tier-2 drugs, and includes brand-name drugs for which there’s either a generic alternative or a more cost-effective brand.</td>
</tr>
</tbody>
</table>

Specialty drugs

<table>
<thead>
<tr>
<th>TIER 4 • Preferred specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>These specialty drugs are generally more cost-effective than specialty drugs in Tier 5 and have the lowest specialty drug copay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIER 5 • Nonpreferred specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>These specialty drugs have the highest copay because there may be a more cost-effective generic or brand option available.</td>
</tr>
</tbody>
</table>

**Specialty drugs**

These drugs treat complex conditions, such as cancer, chronic kidney failure, and multiple sclerosis, and may require special handling and monitoring. For these drugs, you’ll pay coinsurance up to a maximum per prescription. All specialty drugs must be obtained from a Walgreens pharmacy.
3. YOUR DRUG BENEFIT

Keeping down costs with generic drugs

Brand-name medications are expensive. The good news is that generics have identical active ingredients in the same strengths as their brand-name equivalents, but often cost far less. Your prescription will automatically be filled with the generic version of a drug if a generic is available.

DISPENSE AS WRITTEN

Sometimes, physicians prescribe brand-name drugs to be "dispensed as written." We don’t cover the cost of DAW drugs. You’re responsible for the full cost of any DAW prescription that you fill.

Some drugs don’t have a copay

Under the Affordable Care Act, some members can receive certain commonly prescribed drugs without any cost sharing. To get these drugs, you need a prescription from your doctor, and you must meet plan requirements.

For a complete list of these products, please see the Preventive Drug Coverage list online at bcbsm.com/BCNdruglists.

Some drugs need approval

We review the use of certain drugs to make sure that our members receive the most appropriate and cost-effective drug therapy. For example, you may be required to try one or more preferred drugs to treat your health condition (called step therapy), or your doctor may have to get approval before a drug is covered.

If the drug isn’t approved, you may have to pay the full cost of the drug.

Have your doctor contact the BCN Pharmacy Help Desk to request approval for a drug. Or, call Customer Service at the number on the back of your member ID card.
3. YOUR DRUG BENEFIT

Filling a prescription

AT A RETAIL PHARMACY
More than 2,400 retail pharmacies in Michigan and 70,000 retail pharmacies outside of Michigan accept your BCN member ID card. You may fill all prescriptions (except for specialty drugs) at any of these pharmacies. You may also save on your copays by getting a 30-day supply of your prescription at a retail pharmacy.

SPECIALTY DRUGS
Specialty drugs must be ordered from AllianceRx Walgreens Prime.*

Call AllianceRx Walgreens Prime at 866-515-1355.

Or visit alliancerxwp.com.
Blue Care Network of Michigan doesn’t control this website and isn’t responsible for its general content.

LIMITED DISTRIBUTION SPECIALTY DRUGS
There are times when a specialty drug may not be available through AllianceRx Walgreens Prime. In this case, the pharmacy you use will depend on the drug you’re taking. Refer to the Specialty Drug Pharmacy Benefit Member Guide at bcbsm.com/BCNdruglists, and search for the drug you take.

Some drugs and medical supplies aren’t covered

Certain types of drugs and medical supplies may not be covered under your drug plan. These include:

• Brand-name drugs when there’s a generic version available
• Drugs for weight loss
• Drugs used to treat heartburn and acid reflux (except select generic versions)
• Over-the-counter medications (unless considered preventive by the U.S. Preventive Services Task Force)
• Prescription drugs for which there is an over-the-counter equivalent in both strength and dosage form (unless the drug is considered preventive by the U.S Preventive Services Task Force)
• Compounded drugs — with some exceptions
• Cosmetic drugs

*AllianceRx Walgreens Prime is an independent company that provides specialty pharmacy services for Blue Care Network of Michigan.
3. YOUR DRUG BENEFIT

- Products included as a medical benefit (for example: injectable drugs and vaccines that are usually administered in a doctor's office)
  
  **Note:** BCN members can get select vaccines at network retail pharmacies (quantity and age restrictions may apply).

- Replacement prescriptions resulting from loss, theft or mishandling

- Drugs not approved by the FDA

- Drugs used for experimental or investigational purposes

Check your drug rider for additional items that may not be covered.
4. Your Benefits at a Glance

This section has an easy-to-read description of frequently used information about your benefits. This is an overview; it’s not a contract. An official description of your benefits is in your Certificate of Coverage and riders.

Understanding your benefits

The table in this section lists some commonly used benefits and their coverage details.

When reading the table, keep in mind that your cost of sharing is lowest when an in-network doctor treats you. When you see a doctor who’s not in our network, you and your doctor are responsible for getting prior approval from BCN for certain services to be covered. You may also have to pay charges that exceed the BCN-approved amount.

The table is intended to be a summary of your benefits and not a contract. It doesn’t include all benefit limitations and exclusions. You also have access to a Summary of Benefits and Coverage, or SBC, customized for you as required by the Affordable Care Act. The SBC has medical examples to illustrate the benefits of your health care coverage.
4. YOUR BENEFITS AT A GLANCE

For information about all your benefits and any out-of-pocket cost obligations you may have, refer to your Certificate of Coverage and riders.

To see your certificate and riders, log in to your account at bcbsm.com. Click My Coverage in the navigation menu, select Medical from the drop-down menu, click Plan Documents and scroll down to Certificates and Riders.

To view your SBC online, log in to your account at bcbsm.com.

To request a paper copy of these documents, call Customer Service at 1-800-662-6667.

### COMMONLY USED BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Annual Deductible</td>
<td>Coinsurance and Out-of-Pocket Maximum**</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>In-network - $100 per individual; $200 per family deductible per benefit year. Out-of-network - $100 per individual; $200 per family deductible per benefit year. Separate deductible amounts apply for in and out-of-network, they are not combined.</td>
</tr>
<tr>
<td><strong>Annual coinsurance maximum</strong></td>
<td>This plan has no coinsurance maximum.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>Out-of-pocket maximum: In-network - $3,500 per individual/$7,000 per family per benefit year; Out-of-network - $3,500 per individual/$7,000 per family per benefit year. The out-of-pocket maximum is integrated; covered medical, prescription drug and hearing benefits are combined to satisfy the overall out-of-pocket maximum. Separate out-of-pocket maximum amounts apply for in and out-of-network, they are not combined.</td>
</tr>
</tbody>
</table>

### Physician Office Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care physician visits</strong></td>
<td>$20 copay per primary care physician office visit. Referrals from your PCP are not needed to see a specialist in or out-of-network. Preventive services and screenings as mandated by the Affordable Care Act are covered in full in-network. 20% coinsurance of the approved amount out-of-network. See BCBSM.com for a complete list of preventive services. $20 copay per online visit with a designated online BCN participating provider in-network, 20% coinsurance of the approved amount out-of-network.</td>
</tr>
<tr>
<td><strong>Specialist visits</strong></td>
<td>$20 copay after deductible per specialist office visit in-network. 20% coinsurance of the approved amount out-of-network. PCP Referrals are not required for services received either in or out-of-network. Spinal manipulations are unlimited. Preventive services and screenings as mandated by the Affordable Care Act are covered in full in-network only.</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>$20 copay for postnatal maternity visits in-network. Prenatal visits in-network are covered in full. 20% coinsurance of the approved amount after deductible for pre and postnatal maternity visits out-of-network. See Hospital Care below for facility charges.</td>
</tr>
</tbody>
</table>
## 4. YOUR BENEFITS AT A GLANCE

### COMMONLY USED BENEFITS continued

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Office Services</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy office visit</td>
<td>Allergy office visits covered 10% coinsurance after deductible in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room</td>
<td>$75 copay for emergency room treatment in and out-of-network. ER copay waived if admitted as an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>$20 copay after deductible per urgent care visit in and out-of-network</td>
</tr>
<tr>
<td><strong>Emergent ambulance services</strong></td>
<td>Covered in full after deductible for in and out-of-network emergency ambulance transport when other transportation would endanger a member’s life</td>
</tr>
<tr>
<td><strong>Non-emergent ambulance services</strong></td>
<td>Covered in full after deductible for in and out-of-network emergency ambulance transport when other transportation would endanger a member’s life</td>
</tr>
<tr>
<td><strong>Diagnostic and Therapeutic Services</strong></td>
<td></td>
</tr>
<tr>
<td>Lab and pathology services</td>
<td>Lab and pathology services are covered in full in and out-of-network.</td>
</tr>
<tr>
<td>X-ray</td>
<td>10% coinsurance after deductible for radiology services in-network; 20% coinsurance of the approved amount after deductible out-of-network. Prenatal ultrasound and other preventive screenings are covered in full in-network only.</td>
</tr>
<tr>
<td>Outpatient facility visits/diagnostic services</td>
<td>10% coinsurance after deductible for outpatient diagnostic or therapeutic services in-network. 20% coinsurance of the approved amount after deductible out-of-network. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full in-network only.</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>10% coinsurance after deductible for radiation therapy in an inpatient or outpatient facility setting in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>10% coinsurance after deductible for chemotherapy in an inpatient or outpatient facility setting in-network. 20% coinsurance of the approved amount after deductible out-of-network. Chemotherapy drugs are covered in full.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>10% coinsurance after deductible for dialysis treatment in an inpatient or outpatient facility setting in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
</tbody>
</table>
### 4. YOUR BENEFITS AT A GLANCE

#### COMMONLY USED BENEFITS continued

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Inpatient hospital admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis</td>
<td>$150 copay after deductible per inpatient hospital admission in-network; unlimited days. See certificate for specific surgical coinsurance. 20% coinsurance of the approved amount after deductible out-of-network; unlimited days.</td>
</tr>
<tr>
<td>Newborn care</td>
<td>10% coinsurance after deductible for newborn care in an inpatient setting in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>$150 copay after deductible per admission for services in a skilled nursing facility in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Skilled nursing facility days</td>
<td>Skilled nursing care in a skilled nursing facility is unlimited. Requires prior authorization by BCN.</td>
</tr>
<tr>
<td>Hospice</td>
<td>$150 copay after deductible per admission for inpatient hospice in-network. 20% coinsurance of the approved amount after deductible out-of-network. Inpatient care requires prior authorization. $150 copay per visit for outpatient hospice in-network. 20% of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Home care visits</td>
<td>10% coinsurance after deductible for home care visits in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Surgical Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility</td>
<td>10% coinsurance after deductible for outpatient surgery in-network. 20% coinsurance of the approved amount after deductible out-of-network. Preventive services and screenings as mandated by the Affordable Care Act are covered in full in-network only. See certificate for specific surgical coinsurance.</td>
</tr>
<tr>
<td>Second surgical opinion</td>
<td>$20 copay after deductible per visit for a second surgical opinion in-network. 20% coinsurance of the approved amount after deductible out-of-network. PCP Referrals are not required for services received either in or out-of-network.</td>
</tr>
<tr>
<td>Surgical assistant</td>
<td>10% coinsurance after deductible for services performed by a surgical assistant in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>10% coinsurance after deductible for anesthesia in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Sterilization procedures</td>
<td>Female sterilization is covered in full in-network; 20% coinsurance of the approved amount after deductible out-of-network. Male sterilization is covered 10% coinsurance after deductible in-network; 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Elective abortion procedures</td>
<td>10% coinsurance for first trimester elective abortion in and out-of-network. Limited to one procedure per 24 month period.</td>
</tr>
</tbody>
</table>
### 4. YOUR BENEFITS AT A GLANCE

#### COMMONLY USED BENEFITS continued

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
</tr>
<tr>
<td>Weight reduction procedures (criteria required)</td>
<td>10% coinsurance after deductible for weight reduction procedures in-network. 20% coinsurance of the approved amount after deductible for weight reduction procedures out-of-network. Requires prior authorization by BCN. Limited to one procedure per lifetime.</td>
</tr>
<tr>
<td>Orthognathic surgery</td>
<td>10% coinsurance after deductible for orthognathic surgery in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td><strong>Behavioral Health Services (Mental Health Care and Substance Use Disorder)</strong> Call 1-800-482-5982 when you need care.</td>
<td></td>
</tr>
<tr>
<td>Inpatient mental health</td>
<td>$150 copay after deductible per admission for inpatient mental health/partial hospitalization in-network. 20% coinsurance of the approved amount after deductible out-of-network. Requires prior authorization by BCN.</td>
</tr>
<tr>
<td>Inpatient mental health days</td>
<td>Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.</td>
</tr>
<tr>
<td>Inpatient mental health time period</td>
<td>Coordinated by BCN Behavioral Health management</td>
</tr>
<tr>
<td>Outpatient mental health</td>
<td>$20 copay per visit for outpatient/intensive and online mental health in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Outpatient mental health visit limit</td>
<td>Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.</td>
</tr>
<tr>
<td>Outpatient mental health additional visits</td>
<td>Coordinated by BCN Behavioral Health management</td>
</tr>
<tr>
<td>Inpatient substance use disorder</td>
<td>$150 copay after deductible per admission for inpatient substance use disorder in-network. 20% coinsurance of the approved amount after deductible out-of-network. Requires prior authorization by BCN Behavioral Health management.</td>
</tr>
<tr>
<td>Inpatient substance use disorder time period</td>
<td>Coordinated by BCN Behavioral Health management</td>
</tr>
<tr>
<td>Outpatient substance use disorder</td>
<td>$20 copay per visit for outpatient/intensive outpatient substance use disorder in-network. 20% coinsurance of the approved amount after deductible out-of-network. Requires prior authorization by BCN Behavioral Health management.</td>
</tr>
<tr>
<td>Outpatient substance use disorder visit limit</td>
<td>Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.</td>
</tr>
<tr>
<td>Detoxification - substance use disorder</td>
<td>$150 copay after deductible for inpatient detox services in-network; $20 copay per visit for outpatient detox services in-network; 20% coinsurance of the approved amount after deductible for inpatient and outpatient detox services out-of-network. Requires prior authorization by BCN.</td>
</tr>
</tbody>
</table>
## 4. YOUR BENEFITS AT A GLANCE

### COMMONLY USED BENEFITS continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>Durable medical equipment is 10% coinsurance after deductible in-network. Must be preauthorized and obtained from a BCN supplier. Breast pump to support breast feeding is covered in full. Not covered out-of-network.</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>10% coinsurance after deductible for in-network diabetic supplies. Must be preauthorized and obtained from a BCN supplier. Not covered out-of-network.</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>10% coinsurance after deductible for in-network prosthetics. Must be preauthorized and obtained from a BCN supplier. Not covered out-of-network.</td>
</tr>
<tr>
<td>Orthotics</td>
<td>10% coinsurance after deductible for in-network orthotics. Must be preauthorized and obtained from a BCN supplier. Not covered out-of-network.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Custom Select Drug List: Tier 1A - $6 copay, Tier 1B - $25 copay, Tier 2 - $50 copay, Tier 3 - $80 copay, Tier 4 - 20% coinsurance (max $200), Tier 5 - 20% coinsurance (max $300). Drugs for the treatment of sexual dysfunction, cough &amp; cold and prenatal vitamins are covered at the applicable tiered copay. 30-day supply. Preventive medications and Tier 1A contraceptives are covered in full. Prior authorization and step therapy rules apply. Specialty drugs are covered only when obtained from a pharmacy in the BCN Exclusive Pharmacy Network for Specialty Drugs. 90-day retail and mail order are not covered.</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
</tr>
<tr>
<td>Allergy evaluation/serum/testing</td>
<td>10% coinsurance after deductible for allergy related services in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Allergy injections</td>
<td>Allergy injections covered 10% coinsurance after deductible in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Infertility care (criteria required)</td>
<td>10% coinsurance after deductible for infertility services in-network. 20% coinsurance of the approved amount after deductible for infertility services out-of-network. Requires prior authorization by BCN. In-vitro fertilization is not covered.</td>
</tr>
<tr>
<td>Outpatient physical and speech therapy/outpatient rehabilitation</td>
<td>$20 copay per outpatient rehabilitative and habilitative visit in-network. 20% coinsurance of the approved amount after deductible out-of-network.</td>
</tr>
<tr>
<td>Outpatient physical and speech therapy/outpatient rehabilitation limits</td>
<td>Unlimited visits.</td>
</tr>
</tbody>
</table>
### COMMONLY USED BENEFITS continued

<table>
<thead>
<tr>
<th>Other Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autism spectrum disorder</strong></td>
<td>$20 copay per visit for applied behavioral analysis in-network; 20% coinsurance of the approved amount after deductible out-of-network. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits. Requires prior authorization by BCN.</td>
</tr>
<tr>
<td><strong>Temporomandibular joint (TMJ)</strong></td>
<td>10% coinsurance after deductible for TMJ services in-network. 20% coinsurance after deductible for TMJ services out-of-network. Requires prior authorization by BCN.</td>
</tr>
<tr>
<td><strong>Hearing aid and evaluation</strong></td>
<td>10% coinsurance after deductible in-network for hearing aids and exam. 20% coinsurance of the approved amount after deductible out-of-network. Limited to one hearing aid per ear every 6 to 24 month consecutive period per benefit year.</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>For information about your dental coverage call the customer service number on the back of your ID card.</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Routine adult vision exam performed by an optometrist, ophthalmologist or other provider and covered through the medical benefit: $20 copay per visit in-network; 20% coinsurance of the approved amount out-of-network. Routine adult vision exams are limited to 2 vision exams per member per benefit year; and 1 office visit for the fitting of prescription contact lenses per member per benefit year. For routine adult vision coverage information contact BCN customer service 1-800-662-6667. Pediatric Vision is covered in full for an eye exam and prescription glasses, once per calendar year for members up to the age of 19. Frames are chosen from a select collection. For additional pediatric vision coverage information, contact VSP customer service 1-800-877-7195. For information about your vision coverage call the customer service number on the back of your ID card.</td>
</tr>
</tbody>
</table>
5. Information For You

This section contains disclosures, documents and information that we’re required to provide to you.

BCN: Part of the Blue Cross family

Blue Care Network of Michigan is an affiliate of Blue Cross Blue Shield of Michigan; both are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association. BCN is governed by an 18-member board of directors that includes physicians, members and other private citizens, as well as representatives of large business, small business, labor, hospitals and other health care providers.

As an independent licensee of the Blue Cross and Blue Shield Association, we’re required to tell you that:

• The Blue Cross and Blue Shield Association licenses Blue Care Network to offer certain products and services under the Blue Cross and Blue Shield names.

• Blue Care Network is an independent organization governed by its own board of directors and solely responsible for its own debts and other obligations.

• Neither the association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of Blue Care Network’s obligations.

• Blue Care Network files an annual report with the Michigan Department of Insurance and Financial Services.
Your rights and responsibilities

As a member, you have rights and responsibilities. A right is what you can expect from us. A responsibility is what we expect from you.

ALL MEMBERS HAVE THE RIGHT TO...

• Receive information about their care in a manner that is understandable to them.
• Receive medically necessary care as outlined in their Member Handbook and Certificate of Coverage and riders.
• Receive considerate and courteous care with respect for their privacy and human dignity.
• Candidly discuss appropriate, medically necessary treatment options for their health conditions, regardless of cost or benefit coverage.
• Participate with practitioners in decision making regarding their health care.
• Expect confidentiality regarding care and that Blue Care Network adheres to strict internal and external guidelines concerning the members’ protected health information, including the use, access and disclosure of that information or any other information that is of a confidential nature.
• Refuse treatment to the extent permitted by law and be informed of the consequences of their actions.
• Voice concerns or complaints about the health plan or their health care by contacting Customer Service or submitting a formal written grievance through the Member Grievance program.
• Receive clear and understandable written information about Blue Care Network, its services, its practitioners and providers and their rights and responsibilities.
• Review their medical records at their physician’s office by scheduling an appointment during regular business hours.
• Make recommendations regarding members’ rights and responsibilities policies.
• Request the following information from Blue Care Network:
  - The current provider network for their plan
  - The professional credentials of the health care providers who are participating providers with Blue Care Network, including participating providers who are board certified in the specialty of pain medicine and the evaluation and treatment of pain
  - 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
  - Any prior authorization requirement and limitation, restriction or exclusion by service, benefit or type of drug
  - Information about the financial relationships between Blue Care Network and a participating provider
5. INFORMATION ABOUT US

ALL MEMBERS HAVE THE RESPONSIBILITY TO...

- Read their Certificate of Coverage and applicable riders, their Member Handbook and all other materials for members, and call Customer Service with any questions.
- Comply with the plans and instructions for care that they have agreed to with their practitioners.
- Provide, to the extent possible, complete and accurate information that Blue Care Network and its practitioners and providers need in order to provide care for them.
- Make and keep appointments for nonemergent medical care or call if they need to cancel.
- Participate in the medical decisions regarding their health.
- Be considerate and courteous to practitioners, providers, their staff, other patients and Blue Care Network staff.
- Notify Blue Care Network of address changes and additions or deletions of dependents covered by their contracts.
- Protect their BCN ID cards against misuse and call Customer Service immediately if a card is lost or stolen.
- Report to Blue Care Network all other health care coverage or insurance programs that cover their health and their family’s health.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals.

Grievance process

Blue Care Network and your primary care physician are interested in your satisfaction with the services and care you receive. If you have a problem relating to your care, discuss this with your primary care physician first. Often your primary care physician can correct the problem to your satisfaction. You’re always welcome to call Customer Service with any question or problem you have.

If you’re not able to resolve your issue by calling us, we have a formal process that you can use. You have 180 days from the date of discovery of a problem to file a grievance about a decision made by BCN. There are no fees or costs.

For the grievance policy, which includes more detail about your grievance rights and how soon we must respond, go to bcbsm.com/BCNresolveproblems.

Or call Customer Service at 1-800-662-6667 from 8 a.m. to 5:30 p.m. Monday through Friday. TTY users can call 711.
5. INFORMATION ABOUT US

FILING A GRIEVANCE
If you disagree with a BCN decision, you may file a grievance. You, or someone authorized by you in writing, must submit a standard grievance in writing.

✉ By mail: Appeals and Grievance Unit, Blue Care Network, P.O. Box 284, Southfield, MI 48086-5043
📞 Or by fax: 1-866-522-7345

REVIEW BY THE BCN GRIEVANCE PANEL
Your grievance will be reviewed by the BCN Grievance Panel. The individuals who made the first decision are not the same ones involved in the grievance panel. We’ll reply within 30-calendar days for preservice requests and 60-calendar days for postservice requests.

If the grievance is about a clinical issue, we’ll send it for review to an independent medical consultant in the same or similar specialty as the doctor who provided the service.

If the panel denies your grievance, we’ll write to you within five days of the panel review (but no more than 30 days for preservice or 60 days for postservice requests) and explain the reasons for the denial. Please note that the decision may take an additional 10-business days if BCN needs to request medical information. We’ll also tell you what you can do next. At your request and at no charge to you, we’ll provide all documents used in making the decision.

EXTERNAL REVIEW BY THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
If you don’t agree with our decision or if we were late in responding (add 10 business days if we requested additional information), you’ll be considered to have exhausted the internal grievance process. At this point, you may request external review by the Department of Insurance and Financial Services. You must send your grievance no later than 127-calendar days following receipt of our decision. Send your external review request to:

✉ By mail: P.O. Box 30220, Lansing, MI 48909-7720
    or by personal delivery: 530 W. Allegan Street, 7th Floor, Lansing, MI 48933
📞 By phone: 1-877-999-6442, or by fax: 517-284-8838
🌐 Online*: difs.state.mi.us/Complaints/ExternalReview.aspx

*Blue Care Network of Michigan doesn’t control this website or endorse its general content.
5. INFORMATION ABOUT US

EXPEDITED REVIEW FOR APPEALS

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. We’ll 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 in a timely fashion or if we deny your request, you may request an expedited external review from the Department of Insurance and Financial Services within 10-calendar days of receiving our final determination. In some instances, we may waive the requirement to exhaust our internal grievance process.

を持っている医師またはその代理者が、三度目への応募を発動するために、電話で1-800-662-6667、またはファクシミリで1-866-522-7345に連絡すること。  

Quality assurance

MEDICAL REVIEW STANDARDS

Our medical review staff works closely with your doctor to make sure you get good medical care according to standard medical practice and your health benefits package.

Decisions on a member’s care and service are based solely on the appropriateness of care prescribed in relation to each member’s specific medical condition. Our clinical reviewers don’t have financial arrangements that encourage denial of coverage or service. Nurses and physicians employed by Blue Care Network don’t receive bonuses or incentives based on their review decisions. Medical review decisions are based strictly on medical necessity and providing high-quality care for members within the limits of their plan coverage.

OUR PHYSICIANS HAVE THE CREDENTIALS

Your physician is required to meet our strong network affiliation standards. We screen our physicians to find out if they meet our quality requirements for professional training and medical practice.

Verify the license status of our health care providers at michigan.gov/healthlicense*. Or call the Michigan Department of Consumer and Industry Services at 517-241-7849.

WE MONITOR THE CARE YOU GET

Our primary goal is to help you receive appropriate medical care from your physician. Our medical review staff are in close communication with your physician, and we routinely monitor potential underuse of health care services. This activity is part of our comprehensive Utilization Management program that promotes cost-effective and medically appropriate services for members. Call the Customer Service number (with TDD/TTY services) on the back of your BCN ID card to discuss our utilization activities. We’re available by phone during and after normal business hours, and we offer language assistance. Our staff identify themselves by name, title and organization when receiving or returning calls.

*Blue Care Network of Michigan doesn’t control this website or endorse its general content.
We would like you to know:

- By contract, Blue Care Network physicians are required to make decisions about your care based only on your individual health care needs.
- Blue Care Network monitors member health care services to ensure that doctors provide the most appropriate care for their conditions.
- Blue Care Network doesn’t advertise, market or promote specific products or services to you or your doctors when discussing a member’s health condition.
- Blue Care Network doesn’t have financial ownership arrangements with entities engaged in advertising, marketing or providing goods and services. In limited circumstances, BCN may notify you of new products or treatment opportunities.
- Health care providers, including physicians and hospitals, are never paid for denying services.
- Blue Care Network medical review staff don’t have financial arrangements encouraging denials for medically necessary care or services.

**How we determine new health services**

We keep up with changes in health care through an ongoing review of new services, procedures and drug treatments. Our goal is to make coverage decisions in the best interest of our members’ health.

A committee of Blue Care Network physicians, nurses and representatives from different areas in the company is responsible for reviewing new technology requests and making recommendations.

New health services are generally published in *Good Health*, our member magazine.

For more information about how we select new health services, visit bcbsm.com. Type “Blue Care Network Policies and Practices” in the search box.

**Quality management**

Our quality improvement programs provide doctors with information to help improve care. Call our Quality Management department for more information about our programs and guidelines.

Call our Quality Management department at 248-455-2714.

For health information, call Blue Cross Health & Well-Being at 1-800-637-2972.

**Accreditation**

Since 2000, Blue Care Network has received accreditation for plan performance from the National Committee for Quality Assurance. NCQA is a nationally recognized, independent, not-for-profit organization that measures the quality of America’s health care and health plans.
5. INFORMATION ABOUT US

Privacy practices

NOTICE OF PRIVACY PRACTICES
FOR MEMBERS OF OUR NONGROUP AND UNDERWRITTEN GROUP PLANS INCLUDING MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLANS.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AFFILIATED ENTITIES COVERED BY THIS NOTICE
This notice applies to the privacy practices of the following affiliated covered entities that may share your protected health information as needed for treatment, payment and health care operations.

Blue Cross Blue Shield of Michigan
Blue Care Network of Michigan
BCN Service Company
Blue Care of Michigan Inc.

OUR COMMITMENT REGARDING YOUR PROTECTED HEALTH INFORMATION
We understand the importance of your Protected Health Information (hereafter referred to as "PHI") and follow strict polices (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. Our policies cover protection of your PHI whether oral, written or electronic.

In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and given out ("disclosed"). We must follow the privacy practices described in this notice while it is in effect. This notice took effect September 30, 2016, and will remain in effect until we replace or modify it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will provide a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state laws require BCBSM and BCN to condition the disclosure on the recipient’s promise to obtain your written permission to disclose your PHI to someone else.

OUR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
We may use and disclose your PHI for the following purposes without your authorization:

To you and your personal representative: We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you).
5. INFORMATION ABOUT US

For treatment: We may use and disclose your PHI to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. For example, we may disclose your PHI to health care providers in connection with disease and case management programs.

For payment: We may use and disclose your PHI for our payment-related activities and those of health care providers and other health plans, including:
- Obtaining premium payments and determining eligibility for benefits
- Paying claims for health care services that are covered by your health plan
- Responding to inquiries, appeals and grievances
- Coordinating benefits with other insurance you may have

For health care operations: We may use and disclose your PHI for our health care operations, including for example:
- Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation
- Performing outcome assessments and health claims analyses
- Preventing, detecting and investigating fraud and abuse
- Underwriting, rating and reinsurance activities (although we are prohibited from using or disclosing any genetic information for underwriting purposes)
- Coordinating case and disease management activities
- Communicating with you about treatment alternatives or other health-related benefits and services
- Performing business management and other general administrative activities, including systems management and customer service

We may also disclose your PHI to other providers and health plans who have a relationship with you for certain health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

To others involved in your care: We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person’s involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or relative, unless you object.

When required by law: We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers’ compensation laws. We will disclose your PHI when required by the Secretary of the Department of Health and Human Services and state regulatory authorities.
5. INFORMATION ABOUT US

- **For matters in the public interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:
  - Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight
  - Reporting adult abuse, neglect or domestic violence
  - Reporting to organ procurement and tissue donation organizations
  - Averting a serious threat to the health or safety of others

- **For research:** We may use and disclose your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.

- **To communicate with you about health-related products and services:** We may use your PHI to communicate with you about health-related products and services that we provide or are included in your benefits plan. We may use your PHI to communicate with you about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees and add value to your benefits plan.

- **To our business associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

- **To group health plans and plan sponsors:** We participate in an organized health care arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information (although we are prohibited from using or disclosing any genetic information for underwriting purposes). Certain plans and their sponsors may receive additional PHI from BCBSM and BCN. Whenever we disclose PHI to plans or their sponsors, they must follow applicable laws governing use and disclosure of your PHI including amending the plan documents for your group health plan to establish the limited uses and disclosures it may make of your PHI.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Some uses and disclosures of your PHI require a signed authorization:

- **For marketing communications:** Uses and disclosures of your PHI for marketing communications will not be made without a signed authorization except where permitted by law.

- **Sale of PHI:** We will not sell your PHI without a signed authorization except where permitted by law.
5. INFORMATION ABOUT US

- **Psychotherapy notes:** To the extent (if any) that we maintain or receive psychotherapy notes about you, disclosure of these notes will not be made without a signed authorization except where permitted by law.

Any other use or disclosure of your protected health information, except as described in this Notice of Privacy Practices, will not be made without your signed authorization.

DISCLOSURES YOU MAY REQUEST

You may instruct us, and give your written authorization, to disclose your PHI to another party for any purpose. We require your authorization to be on our standard form.

To obtain the form, call Customer Service at 1-800-662-6667 or 313-225-9000.

Forms are also available at bcbsm.com.

INDIVIDUAL RIGHTS

You have the following rights. To exercise these rights, you must make a written request on our standard forms.

To obtain the forms, call Customer Service at 1-800-662-6667 or 313-225-9000.

Forms are also available at bcbsm.com.

- **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable cost-based fee for copying and postage. You may request that these materials be provided to you in written form or, in certain circumstances, electronic form. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

- **Disclosure accounting:** You have the right to an accounting of disclosures, we, or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment and health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

  You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

- **Restriction requests:** You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment or health care operations. We are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.
5. INFORMATION ABOUT US

- **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under "Access." If we deny your request, we will provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.

- **Confidential communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits Statement to a post office box instead of to the subscriber’s address.

  To request confidential communications, call Customer Service at 1-800-662-6667 or 313-225-9000.

- **Breach notification:** In the event of a breach of your unsecured PHI, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or a written copy of this notice:

- Write us at: Blue Cross Blue Shield of Michigan, Attn: Privacy Official, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226-2998.
- Or call us at 313-225-9000.
- For your convenience, you may also obtain an electronic (downloadable) copy of this notice online at bcbsm.com.

If you are concerned that we may have violated your privacy rights, or you believe that we have inappropriately used or disclosed your PHI:

- Call us at 1-800-552-8278.
- You may also complete our Privacy Complaint Form online at bcbsm.com.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We will not retaliate in any way if you file a complaint with us or with the U.S. Department of Health and Human Services.
6. Your benefit documents

The documents that follow provide details about your benefits, including what you may owe when you get services. These documents are the contract between you, your group and Blue Care Network.
This Certificate of Coverage (Certificate) describes the Benefits provided to you. It is a contract between you as an enrolled Member and Blue Care Network of Michigan (BCN). It includes General Provisions and Your Benefits.

This Certificate is a student health plan through 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 obligations created under the contract
- There are no additional obligations on the part of BCN other than those obligations stated under the provisions of the contract with BCN

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

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

This Plan is available for University of Michigan (U of M) students and their eligible Dependents. As a BCN Member, you, agree to the rules as stated in the General Provisions and Your Benefits chapters.

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

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

Blue Care Network
20500 Civic Center Drive
Southfield, MI 48076
800-662-6667
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 later sections as necessary. In addition to these terms, use of terms “we”, “us” and “our” refer to BCN or another entity or person BCN authorizes to act on its behalf. The terms “you” or “your” refer to the Member who is enrolled with BCN as either a Subscriber or Family Dependent.

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

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

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

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

Balance Billing, sometimes called extra billing, is when a provider bills you for the difference between their charge and the Approved Amount. A BCN Participating Provider may not balance bill you for Covered Services.

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

Benefit Year is the one-year period designated by U of M and BCN of when your Benefits reset. It begins on the date as determined by U of M and BCN.

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

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

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

Chronic is a disease or ailment that is not temporary or recurs frequently. Arthritis, heart disease, major depression and schizophrenia are examples of Chronic diseases.
Coinsurance is your share of the costs of a Covered Service calculated as a percentage of the BCN Approved Amount that you owe after you pay any Deductible. This amount is determined based on the Approved Amount at the time the claims are processed. Your Coinsurance is not altered by an audit, adjustment or recovery. Your Coinsurance is added or amended when a Rider is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

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

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

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

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

Coverage Period is a period during which an enrolled Member is entitled to Coverage. Coverage will become effective at 12:01 AM on the coverage start date and will terminate at 11:59 PM on the coverage end date as designated by UofM.

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

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

Deductible is the amount that you owe for health care services before we pay. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed. Your Deductible is not altered by an audit, adjustment, or recovery. Your Deductible amount is added or amended when a Rider is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.
**Dependent Child** is an eligible individual under the age of 26 who is the son or daughter in relation to the Subscriber or spouse by birth or legal adoption or for whom the Subscriber or spouse has legal guardianship. NOTE: A Principally Supported Child is not a Dependent Child for purposes of this Certificate. (See definition of Principally Supported Child)

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

- The use or prescription of a drug or device intended as a contraceptive
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman’s pregnancy if the woman’s physical condition, in the physician’s reasonable medical judgment, necessitates the termination of the woman’s pregnancy to avert her death
- Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy

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

**Enrollment** is the process of you giving your information to the University of Michigan and the Group sending it to us.

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

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

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

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

**Group** is the University of Michigan who has entered into a contract to provide health care for its eligible students.

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

Hospital is a Participating Acute Care Facility that provides continuous, 24-hour Inpatient medical, surgical or obstetrical care. The term “Hospital” does not include a Facility that is primarily a nursing care Facility, rest home, home for the aged or a Facility to treat substance use disorder, psychiatric disorders or pulmonary tuberculosis.

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

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

Medical Director (when used in this document) means BCN’s Chief Medical Officer (“CMO”) or a designated representative.

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

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

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

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

Non-Participating Provider is an individual, Facility, or other health care entity not under contract with BCN. Non-Participating Providers must be appropriately licensed to perform the Covered Health Service provided. Services provided by a Non-Participating Provider are subject to applicable Deductible, Copayment, and/or Coinsurance. Unless the specific service is
Preauthorized as required under this Certificate, a Non-Participating Provider may bill you for services and you will be responsible for the entire bill.

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

Online Visit is a structured real-time online health consultation using secure audio-visual technology to connect a BCN Participating Provider in one location to a Member in another location. The Online Visit is for the purpose of diagnosing and providing medical or other health treatment for low-complexity conditions within the provider’s scope of practice.

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

Out-of-Network Benefits are Covered Services that are provided by a Non-Participating Physician or other Non-Participating provider in an office or Facility. Out-of-Network Benefits are paid at a lower level than In-Network Benefits.

Out-of-Pocket Maximum is the most you have to pay for Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your medical and pharmacy Deductible, Copayment and Coinsurance. This limit never includes your premium, Balance Billed charges or health care that we do not cover. Out-of-Pocket Maximum amount may be amended when a Rider is attached.

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

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.

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

Premium is the amount you are required to pay BCN for continued health care Coverage.
Preventive Care is care designed to maintain health and prevent disease. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

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

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Principally Supported Child is an individual less than 26 years for whom principal financial support is provided by the Subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for Coverage. A Principally Supported Child must meet the requirements stated in Section (1).

NOTE: A Principally Supported Child is not the same as a Dependent Child.

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

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Chiropractic (DC)
- Physician Assistant (PA)
- Certified Nurse Practitioner (CNP)
- Licensed Psychologist (LP)
- Limited License Psychologist (LLP)
- Licensed Professional Counselor (LPC)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Certified Nurse Midwife (CNM)
- Board Certified Behavior Analyst (BCBA)
- Clinical Nurse Specialist-Certified (CNS-C)
- Other providers as identified by BCN

Rehabilitation Services are health care services that help a person keep, get back or improve skills and functions for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Rescission is the retroactive termination of a contract due to fraud or intentional misrepresentation of material fact.
Respite Care is temporary care provided in a nursing home, hospice Inpatient Facility, or Hospital so that a family member, friend or caregiver can rest or take some time off from caring for you.

Rider is an amendment to this Certificate that describes any changes (addition, modifications, deletion or revision) to Coverage. A Rider also applies or amends Cost Sharing and Benefit Maximums to select Covered Services. When there is a conflict between the Certificate and a Rider, the Rider shall control over the Certificate.

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

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

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

Skilled Care are services that:
- Require the skills of qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists and speech pathologists and must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the Member and to achieve medically desired result
- Are ordered by the attending physician
- Are Medically Necessary according to generally accepted medical standards
  - Examples include intravenous medication including administration; complex wound care and rehabilitation services.

Skilled Care does not include private duty or hourly nursing, respite care, or other supportive or personal care services such as administration or routine medications, eye drops and ointments.

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

Subscriber is the eligible student who has enrolled for health care Coverage with BCN. This student’s enrollment is the basis for Coverage eligibility. This person is also referred to as the “Member”. NOTE: See Section 1 for eligibility requirements.

Telemedicine is a secure real-time health care service, delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Telemedicine visits are for the purpose of treating an ongoing condition that is expected to result in multiple visits before
the condition is resolved or stabilized. Contact for these services must be initiated by you or your provider and must be within your provider's scope of practice. Unlike Online visits, Telemedicine visits require an originating site which is the location of the Member at the time the service occurs. Originating site can be either the provider's office, hospital, or other qualified health centers.

University Health Services (UHS)- is the University of Michigan's on-campus health Facility for Domestic students and their spouses/partners enrolled at the Ann Arbor campus. Medical Services are provided by board-certified physicians and other certified medical professionals.

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

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>ii</td>
</tr>
<tr>
<td>Chapter 1 — GENERAL PROVISIONS</td>
<td>1</td>
</tr>
<tr>
<td>Section 1: Eligibility, Enrollment, and Effective Date of Coverage</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Subscribers</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Family Dependent</td>
<td>1</td>
</tr>
<tr>
<td>1.3 Dependent under a Qualified Medical Child Support Order</td>
<td>3</td>
</tr>
<tr>
<td>1.4 Principally Supported Child</td>
<td>4</td>
</tr>
<tr>
<td>1.5 Additional Eligibility Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>Section 2: Other Party Liability</td>
<td>5</td>
</tr>
<tr>
<td>2.1 Non-Duplication</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Auto Policy and Workers’ Compensation Claims</td>
<td>5</td>
</tr>
<tr>
<td>2.3 Coordination of Benefits</td>
<td>6</td>
</tr>
<tr>
<td>2.4 Subrogation and Reimbursement</td>
<td>7</td>
</tr>
<tr>
<td>Section 3: Member Rights and Responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>3.1 Confidentiality of Health Care Records</td>
<td>9</td>
</tr>
<tr>
<td>3.2 Inspection of Medical Records</td>
<td>9</td>
</tr>
<tr>
<td>3.3 Primary Care Physician (PCP)</td>
<td>9</td>
</tr>
<tr>
<td>3.4 Refusal to Accept Treatment</td>
<td>10</td>
</tr>
<tr>
<td>3.5 Grievance Procedure</td>
<td>10</td>
</tr>
<tr>
<td>3.6 Additional Member Responsibilities</td>
<td>12</td>
</tr>
<tr>
<td>3.7 Member's Role in Policy-Making</td>
<td>13</td>
</tr>
<tr>
<td>3.8 Preauthorization Process</td>
<td>13</td>
</tr>
<tr>
<td>Section 4: Forms, Identification Cards, Records and Claims</td>
<td>15</td>
</tr>
<tr>
<td>4.1 Forms and Applications</td>
<td>15</td>
</tr>
<tr>
<td>4.2 Identification Card</td>
<td>15</td>
</tr>
<tr>
<td>4.3 Misuse of Identification Card</td>
<td>16</td>
</tr>
<tr>
<td>4.4 Membership Records</td>
<td>16</td>
</tr>
<tr>
<td>4.5 Authorization to Receive Information</td>
<td>16</td>
</tr>
<tr>
<td>4.6 Member Reimbursement</td>
<td>16</td>
</tr>
<tr>
<td>Section 5: Termination of Coverage</td>
<td>17</td>
</tr>
<tr>
<td>5.1 Termination of Coverage</td>
<td>17</td>
</tr>
<tr>
<td>5.2 Termination for Nonpayment</td>
<td>17</td>
</tr>
<tr>
<td>5.3 Termination of a Member's Coverage</td>
<td>18</td>
</tr>
<tr>
<td>5.4 Extension of Benefits</td>
<td>19</td>
</tr>
<tr>
<td>Section 6: Continuation Coverage</td>
<td>19</td>
</tr>
<tr>
<td>6.1 Loss of Coverage by Dependent</td>
<td>19</td>
</tr>
<tr>
<td>Section 7: Additional Provisions</td>
<td>19</td>
</tr>
<tr>
<td>7.1 Notice</td>
<td>19</td>
</tr>
</tbody>
</table>
8.25 Temporomandibular Joint Syndrome (TMJ) Treatment ........................................................... 69
8.26 Orthognathic Surgery ........................................................................................................ 70
8.27 Weight Reduction Procedures .......................................................................................... 71
8.28 Prescription Drugs and Supplies ...................................................................................... 71
8.29 Clinical Trials .................................................................................................................. 73
8.30 Gender Dysphoria Treatment .......................................................................................... 75
8.31 Adult Vision Exam ........................................................................................................... 76
Section 9: Exclusions and Limitations ..................................................................................... 77
9.1 Unauthorized Services ......................................................................................................... 77
9.2 Services Received While a Member .................................................................................... 77
9.3 Services that are not Medically Necessary ....................................................................... 77
9.4 Non-Covered Services ....................................................................................................... 77
9.5 Cosmetic Surgery .............................................................................................................. 79
9.6 Prescription Drugs ............................................................................................................. 79
9.7 Military Care ...................................................................................................................... 79
9.8 Custodial Care .................................................................................................................. 79
9.9 Comfort Items .................................................................................................................. 79
9.11 Elective Procedures ........................................................................................................... 80
9.12 Maternity Services ........................................................................................................... 80
9.13 Dental Services ................................................................................................................ 80
9.14 Services Covered Through Other Programs .................................................................... 81
9.15 Alternative Services .......................................................................................................... 81
9.16 Vision Services ................................................................................................................ 82
9.17 Hearing Aid Services ........................................................................................................ 82
9.18 Out of Area Services ......................................................................................................... 82
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 the University of Michigan and BCN. Certain requirements depend on whether you are one of the following:

- University of Michigan Student
- Family Dependent
- Dependent under a Qualified Medical Child Support Order (Children up to the age of 26)
- Dependents of International student who arrive in the USA with a valid Visa or Passport

1.1 Subscribers

Eligibility
A Subscriber must meet the University of Michigan’s eligibility requirements for the Domestic or International student plans.

Please check https://uhs.umich.edu/healthinsuranceplans for eligibility guidelines for both the Domestic and International students.

Enrollment
You can enroll during:
- The enrollment periods set by University of Michigan.
- A qualifying event outside the enrollment period such as loss of coverage. BCN must be contacted within 31 days of the event.

Please check https://uhs.umich.edu/healthinsuranceplans for enrollment period dates for both the Domestic and International students.

Effective Date
Coverage for all insured University of Michigan students will become effective at 12:01 AM on each Coverage Period start date, and end at 11:59 PM on each Coverage Period end date as determined by University of Michigan.

1.2 Family Dependent

Eligibility
A Family Dependent may be:
- The legally married spouse of the Subscriber and who meets the University of Michigan’s eligibility requirements. For domestic partner coverage, please see attached Rider.
• Dependent Child - a Subscriber's child under age 26 including natural child, step child, legally adopted child or child placed for adoption. The Dependent Child's spouse is not covered under this Certificate. The Dependent Child's children may be covered in limited circumstances.

   NOTE: Newborn children, including grandchildren, may qualify for limited benefits immediately following their birth even if they are not listed on your contract. See maternity care in the Inpatient Hospital Services section of this Certificate.

• A Dependent under a Qualified Medical Child Support Order

**Dependent Children** and a Dependent under a Qualified Medical Child Support Order are eligible for Coverage until the end of the Coverage Period they turn 26. The child's BCN membership terminates on the last day of the Coverage Period.

**Exception:** An unmarried Dependent Child and a Dependent under a Qualified Medical Child Support Order who becomes 26 while enrolled and who is totally and permanently disabled may continue health care 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 with the Subscriber
- The disability began before their 26th birthday

Physician certification, verifying the child's disability and that it occurred prior to the child's 26th birthday, must be submitted to BCN within 31 days of the end of the Calendar Year in which the dependent child turns 26.

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

**NOTE:** A Dependent Child whose only disability is a learning disability or Substance Use Disorder does not qualify for health care Coverage under this exception.

**Enrollment**

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

- During the Enrollment Periods established by the University of Michigan
- When the Subscriber enrolls
- Within 31 days of a “qualifying event,” that is, birth, marriage, placement for adoption, qualified medical child support order. **NOTE:** See below for additional requirements for Dependents under a Qualified Medical Child Support Order
- Adopted children are eligible for health care Coverage from the date of placement. **NOTE:** Placement means when the Subscriber becomes legally responsible for the child; therefore, the child's Coverage may begin before the child lives in the Subscriber’s home
If the eligible Family Dependents were not enrolled because of other coverage, and they lose their coverage, the Subscriber may add them within 31 days of their loss of coverage with supporting documentation.

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

**Effective Date of Coverage - Other than Dependent under a Qualified Medical Child Support Order**

- Coverage is effective on the date of the qualifying event, if the Family Dependent is enrolled within 31 days of the event.
- If the Family Dependent is not enrolled within 31 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- For a Family Dependent who lost coverage and notifies BCN within 31 days, Coverage will be effective when the previous coverage lapses. If you do not notify BCN within 31 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- Adopted children are eligible for Coverage from the date of placement. Note: Placement means when the Subscriber becomes totally responsible for the child; therefore, the child's Coverage may begin before the child lives in the Subscriber's home.

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

**Eligibility**

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

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

**Enrollment**

The Dependent Child under this section may be enrolled at any time, preferably within 31 days of the court order. In addition:

- If the Subscriber parent who is under court order to provide Coverage does not apply, the other parent or the state Medicaid agency may apply for Coverage for the child.
- A Subscriber parent who has individual Coverage must change from individual Coverage to 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 31 days of the court or administrative order, Coverage is effective as of the date of the order.
- If BCN receives notice longer than 31 days after the order is issued, Coverage is effective on the date BCN receives notice.

**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 old
- Be unmarried
- Live full-time in the home with the Subscriber
- Not be eligible for Medicare or other group Coverage
- Be dependent on the Subscriber for principal financial support in accordance with Internal Revenue Service standards, and have met these standards for at least 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:
- Evidence that the child was reported as a dependent on the Subscriber's most recently filed tax return, or evidence of a sworn statement that the child qualifies for dependent tax status in the current year; and
- Proof of eligibility - if we request it

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

**1.5 Additional Eligibility Guidelines**
The following guidelines apply to all Members:

**Medicare**: You are not eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this plan.

If you obtain Medicare after you enrolled in this student plan, your coverage under this plan will not end.
As used here, “have Medicare” means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

- **Change of Status**: You agree to notify us within 31 days of any change in eligibility status of you or any Members on the Contract. When you are no longer eligible for Coverage, you are responsible for payment for any Services or Benefits.

- 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
- Are not Covered Service under this Certificate

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

#### 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 provider are not eligible to be paid by both BCN and another health plan or another insurance policy.
- This is a coordinated Certificate, meaning Coverage described in this Certificate will be reduced to the extent that the Services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for the payment under such health plan or policy.

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

- This Certificate is a coordinated Certificate of Coverage. This means that for medical care needed as the result of an automobile accident, if the Member has a coordinated no-fault
insurance policy, then BCN will assume primary liability for Covered Services. The no-fault automobile insurance would be secondary.

If the Member has coverage through a non-coordinated (sometimes called a “full medical”) no-fault automobile insurance policy, then the automobile insurance will be considered the primary plan. BCN would pay Coverage under this Certificate as the secondary plan.

- If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member’s medical Services. BCN would provide for Covered Services under this Certificate as the secondary plan.

If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. BCN would pay for Covered Services under this Certificate as the secondary plan. If the motorcycle insurance does not provide medical coverage or if that medical coverage is exhausted, then BCN will pay for Covered Services under this Certificate as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCN will pay secondary.

- Services and treatment for any work-related injury that is paid, payable or required to be provided under any workers’ compensation law or program will not be paid by BCN.

- If any such Services are paid or provided by BCN, BCN has the right to seek reimbursement from the other program, insurer or Member who has received reimbursement.

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

2.3 Coordination of Benefits

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

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

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

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

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

Definitions

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

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

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

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

“First Priority Security Interest” means the right to be paid before any other person from any money or other valuable consideration recovered by
  • Judgment or settlement of a legal action
  • Settlement not due to legal action
  • Undisputed payment

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

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

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

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

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

- You assign to us your right to recover what BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a Lien or Right of Recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.
- You agree to inform BCN when your medical expenses should have been paid by another party but were not due to some act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your attorney of BCN rights and your obligations under this Certificate.
- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining written consent from BCN if the settlement relates to Services paid by BCN.
- You agree to cooperate with BCN in our efforts to recover money we paid on your behalf.
- You acknowledge and agree that this Certificate supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.
- You acknowledge and agree that this Certificate is a contract between you and BCN and any failure by you, other Members on the Contract or representatives to follow the terms of this Certificate will be a material breach of your contract with us.

a. When you accept a BCN ID card for Coverage, you agree that, as a condition of receiving Benefits and Services under this Certificate, you will make every effort to recover funds from the liable party.

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

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

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

e. If you refuse or do not cooperate with BCN regarding subrogation, it will be grounds for terminating membership in BCN upon 30 days written advance notice. BCN will have the right to recover from you the value of Services and Benefits provided to you.
Section 3: Member Rights and Responsibilities

3.1 Confidentiality of 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 required by or as may be permissible under law.

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

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

3.3 Primary Care Physician (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”).

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

Information on how to select a Primary Care Physician, and for a list of Participating Primary Care Physicians, Participating pediatricians and Participating health care professionals (including certified and registered nurse midwives) who specialize in obstetrics or gynecology is
available at 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 will be asked to disenroll upon 30 days written advance notice; all Dependent Family Members will also be required to disenroll from Coverage. (See Section 5)

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

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

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

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

At any step of the Grievance process, you may submit any written materials to help us in our review. You have 180 days from the date of discovery of a problem to file a Grievance with or appeal a decision of BCN. There are no fees or costs charged to you when filing a Grievance.

Definitions
Adverse Benefit Determination - means any of the following:

- A request for a benefit, on application of any utilization review technique, does not meet the requirements for medical necessity, appropriateness, 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 prospective or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit
- A rescission of coverage determination
- Failure to respond in a timely manner to request for a determination

Pre-Service Grievance is an appeal that you can file when you disagree with our decision not to pre-approve a Service you have not yet received.

Post-Service Grievance is 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 284  
Southfield, MI  48086-5043  
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 Grievances and 60 calendar days for Post-Service Grievances.

The person or persons who made the initial determination are not the same individuals involved in 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 or our internal grievance process is waived, you may appeal to Department of Insurance & Financial Services (DIFS) at https://difs.state.mi.us/Complaints/ExternalReview.aspx or at the addresses listed below.
When filing a request for an external review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If we fail to provide you with our final determination within 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.

**Expedited review**

Under certain circumstances – if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review – you can request an expedited review. You, your doctor or someone acting on your behalf can initiate an expedited review by calling Customer Service or faxing us at 866-522-7345.

We will decide within 72 hours of receiving both your grievance and your physician’s confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days. If we fail to provide you with our final determination timely or you receive an adverse determination, you may request an expedited external review from DIFS within 10-calendar days of receiving our final determination. In some instances, we may waive the requirement to exhaust our internal grievance process.

### 3.6 Additional Member Responsibilities

You have the responsibility to:

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

### 3.7 Member's Role in Policy-Making
At least one third of the Board of Directors of BCN will consist of BCN Members, elected by Subscribers. BCN provides nomination and election procedures to Subscribers every three years.

### 3.8 Preauthorization Process
Some Services and supplies require Preauthorization by BCN. Section 8 tells you which Services and supplies need Preauthorization. You can get a complete and detailed list by contacting Customer Service at the number on the back of your BCN ID card. The list may change from time to time.

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

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Time to Request Additional Information</th>
<th>Time to Obtain Additional Information</th>
<th>Time to Decision</th>
<th>Time to Initial Notification</th>
<th>Time to Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service urgent requests requiring additional information</td>
<td>Within 24 hours of receipt of request</td>
<td>Within 48 hours of notifying provider of the need for additional information</td>
<td>Within 72 hours from receipt of request</td>
<td>Practitioner notified by telephone or fax within 72 hours from receipt of request for approvals or denials</td>
<td>Written notification is given to Member and provider within 3 days from initial oral notification</td>
</tr>
<tr>
<td>Pre-Service urgent requests with all information</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Within 24 hours of receipt of request</td>
<td>Practitioner notified by telephone or fax within 24 hours from receipt of request for approvals or denials</td>
<td>Written notification is given to Member and provider within 3 days from initial oral notification</td>
</tr>
<tr>
<td>Pre-Service nonurgent</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Within 14 days from</td>
<td>Initial notification is given to</td>
<td>Written notification is given to</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Time to Request Additional Information</td>
<td>Time to Obtain Additional Information</td>
<td>Time to Decision</td>
<td>Time to Initial Notification</td>
<td>Time to Written Notification</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>requests with all information</td>
<td>receipt of request</td>
<td>receipt of request</td>
<td>Initial notification is given to Member and provider within 14 days from receipt of request</td>
<td>Written notification is given to Member and provider within 14 days from receipt of request</td>
<td></td>
</tr>
<tr>
<td>Pre-Service nonurgent requests requiring additional information</td>
<td>Within 5 days of receipt of request</td>
<td>Within a minimum of 45 days of receipt for information</td>
<td>Initial notification is given to Member and provider within 14 days from receipt of information</td>
<td>Written notification is given to Member and provider within 14 days from receipt of information</td>
<td></td>
</tr>
<tr>
<td>Urgent Concurrent care with all information</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Initial notification is given to provider within 24 hours of receipt of request</td>
<td>Written notification of denial is sent to Member and provider within 3 days from initial oral notification</td>
<td></td>
</tr>
<tr>
<td>Urgent concurrent care requiring additional information</td>
<td>Within 24 hours of receipt of request</td>
<td>Within 48 hours of notifying provider of the need for additional information</td>
<td>Initial notification is given to provider within 72 hours of receipt of request</td>
<td>Written notification of denial is sent to Member and provider within 3 days from initial oral notification</td>
<td></td>
</tr>
<tr>
<td>Urgent concurrent care: The request to extend concurrent care was not made prior to 24 hours before the receipt of the request</td>
<td>Within 24 hours of receipt of request</td>
<td>Within 48 hours of notifying provider of the need for additional information</td>
<td>Practitioner notified by telephone or fax within 72 hours from receipt of request</td>
<td>Written notification is given to member and provider within 3 days from initial oral notification</td>
<td></td>
</tr>
<tr>
<td>Type of Request</td>
<td>Time to Request Additional Information</td>
<td>Time to Obtain Additional Information</td>
<td>Time to Decision</td>
<td>Time to Initial Notification</td>
<td>Time to Written Notification</td>
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</tr>
<tr>
<td>expiration of the prescribed period of time or number of treatments</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Within 30 days of receipt of request</td>
<td>Not applicable</td>
<td>Within 30 days of receipt of request</td>
</tr>
<tr>
<td>Post-Service requests with all information</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Within 30 days of receipt of request</td>
<td>Not applicable</td>
<td>Within 30 days of receipt of request</td>
</tr>
<tr>
<td>Post-Service requests requiring additional information</td>
<td>Within 5 days of receipt of request - Written request for information is sent to Member and provider</td>
<td>Within a minimum of 45 days of request for information</td>
<td>Within 14 days of receipt of information</td>
<td>Not applicable</td>
<td>Written notification is given to member and provider within 14 days from receipt of information</td>
</tr>
</tbody>
</table>

### Section 4: Forms, Identification Cards, Records and Claims

#### 4.1 Forms and Applications

You must complete and submit any enrollment form or other forms that BCN requests. You represent that any information you submit is true, correct and complete. The submission of false or misleading information in connection with Coverage is cause for Rescission of your Contract upon 30 days written advance notice.

You have the right to appeal our decision to Rescind your Coverage by following the Grievance procedure as described in Section 3 and in the Member Handbook. The Grievance procedure is also on our website at bcbsm.com. 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 for whom all premiums have been paid. If the person is not entitled to receive Services, the person must pay for the Services received.
If you have not received your card or your card is lost or stolen, please contact Customer Service immediately by calling the number listed in the Member Handbook. Information regarding how to obtain a new BCN ID card is also on our website at bcbsm.com.

4.3 Misuse of Identification Card
BCN may confiscate your identification card and may terminate all rights under this Certificate if you misuse your identification card by doing any of the following:
- Permit any other person to use the card
- Attempt to or defraud BCN or a provider

4.4 Membership Records
- We maintain Membership records
- Benefits under this Certificate will not be available unless the Member submits information in a satisfactory format.
- You are responsible for correcting any inaccurate information provided to BCN. If you intentionally fail to correct inaccurate information, you will be responsible to reimburse BCN for any Service paid based on the incorrect information.

4.5 Authorization to Receive Information
By accepting Coverage under this Certificate, you agree that:
- BCN may obtain any information from providers in connection with Services provided;
- BCN may disclose your medical information to your Primary Care Physician or other treating physicians or as otherwise permitted by law; and
- BCN may copy records related to your care.

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

Additional information on how to submit a claim and the Reimbursement Form is available at bcbsm.com and in the Member Handbook. Send your itemized medical bills promptly to us.

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

NOTE: Written proof of payment must be submitted within 12 months of the date of Service. Claims submitted 12 months after the date of Service will not be paid.
Section 5: Termination of Coverage

5.1 Termination of Coverage
This Certificate is guaranteed renewable and will continue in effect unless terminated as follows:

- This Certificate may be terminated by BCN 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.

5.2 Termination for Nonpayment

Nonpayment of Premium
- If you fail to pay the premium by the due date, you are in default. BCN allows a 30-day grace period; however, if the default continues, you and your Dependents will be terminated.

- If the Coverage is terminated, any Covered Services incurred by you or your Dependents and paid by BCN after the date of the last full payment will be charged to you, as permitted by law.

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 provider to correct the situation.

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

5.3 Termination of a Member’s Coverage
a) Termination
Coverage for any Member may 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
- The student policy ends
- 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
- Your group changes to a non-BCN health plan
- We no longer offer this coverage
- The date you withdraw from the school because of entering the armed forces of any country

If your coverage ends because you withdraw from school for reasons other than entering the armed forces, we will not refund premium contributions. You are covered for the policy term for which you enrolled and paid the premium contribution.

If you withdraw from school because you have entered the armed forces, premiums will be refunded, on a prorated basis, when you receive your application within 90 days from the date of the withdrawal.

b) Rescission
If you commit fraud that in any way affects your Coverage or make an intentional misrepresentation of material fact to obtain, maintain or that otherwise affects your Coverage, BCN will consider you in breach of contract and, upon 30 days written advance notice your membership may be Rescinded. Once we notify you that we are rescinding your Coverage, we may hold or reject claims during this 30-day period. In some circumstances, fraud or intentional misrepresentation of a material fact may include:

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

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

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

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

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

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

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

Section 6: Continuation Coverage

6.1 Loss of Coverage by Dependent

Coverage for Dependents will end when the Coverage for the student ends. Before then Coverage will end:

- The date the covered student fails to pay any required premium.
- For the Spouse, the date the marriage ends in divorce or annulment.
- The date the Dependent Coverage is deleted from the Plan.

Section 7: Additional Provisions

7.1 Notice

Any notice that BCN is required to give to you will be:

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

7.2 Change of Address

You must update Membership records immediately when you change your address.
7.3 **Headings**
The titles and headings in this Certificate are not intended as part of this Certificate. They are intended to make your Certificate easier to read and understand.

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

7.5 **Execution of Contract Coverage**
When you enroll with BCN 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 and Member Handbook**
Reasonable policies, procedures, rules and interpretations may be adopted in order to administer this Certificate. Your Benefits include additional programs and Services as set forth in the Member Handbook.

7.8 **Time Limit for Legal Actions**
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 law action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

7.9 **Your Contract**
Your contract consists of the following:
- Your Certificate of Coverage
- Any attached Riders
- Your Member Handbook
- The application signed by the Subscriber
- The BCN Identification card
Your Coverage is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us. BCN does not:
- Adjust premiums based on genetic information
- Request/require genetic testing
- Collect genetic information from an individual at any time for underwriting purposes

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

7.10 Reliance on Verbal Communication and Waiver by Agents

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

No agent or any other person, except an officer of BCN has the authority to do either of the following:
- Waive any conditions or restrictions of this Certificate
- Extend the time for making payment.

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

7.11 Amendments

This Certificate and the contract between University of Michigan and BCN are subject to amendment, modification or termination.

Such changes must be made in accordance with the terms of this Certificate or by mutual agreement between University of Michigan and BCN with regulatory approval and with prior notice.

7.12 Major Disasters

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

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

Such circumstances include, but are not limited to:
- Complete or partial disruption of facilities
- Disability of a significant part of facility or BCN personnel
- War
- Riot
- Civil insurrection
- Labor disputes not within the control of BCN

7.13 Obtaining Additional Information
The following information is available to you by writing to:

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

You can also call our Customer Service Department at the number shown on the back of your BCN ID card.

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

NOTE: Some of this information is found in the Member Handbook and at bcbsm.com.

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

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

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

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

7.18 Termination of Coverage and Refund Policy
Your student Coverage will end on the first of these to occur:

- The date this Plan terminates.
- The last day for which any required premium has been paid.
- The date on which the Covered student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal.
- The date on which the Covered student is no longer in an eligible class.

NOTE: If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term for which they are enrolled, and for which premium has been paid.

Refund Policy
If you cancel your Coverage within the first 31 days of a Coverage Period, you will not be covered and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period you have paid the premium for, and no refund will be allowed. This Refund Policy will not apply if you withdraw due to covered accident or sickness.

Exception: A Covered Person entering the armed forces of any country will not be covered under this Certificate as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any Covered Dependent upon written request received by BCN within 90 days of withdrawal from school.
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 provided are in accordance with Certificate requirements and, when required, are Preauthorized or approved by BCN except in an Emergency.

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

- A Preauthorization is not a guarantee of payment. All claims are subject to:
  - Review of the diagnosis reported
  - Verification of Medical Necessity
  - Availability of Benefits at the time the claim is processed
  - Conditions, limitations, exclusions, maximums
  - Coinsurance, Copayments and Deductible under your Certificate and Riders

- If you receive services that we do not cover, you will pay for that service.

- If you purchase a deluxe item or equipment when not Medically Necessary, the Approved Amount for the basic item applies toward the price of the deluxe item. You are responsible for any costs over the Approved Amount.

- Coverage is subject to the limitations and exclusions listed in this Chapter.

- A Rider may be attached to this Certificate. It amends or applies 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 have other Benefits and Services like:
  - Disease management
  - Prevention
  - Wellness
  - Care management services.

You can find more details in the Member Handbook and on bcbsm.com.
Section 8: Your Benefits

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

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

This Plan allows you the option to choose where to receive your health care. You may obtain Covered health care services directly from University Health Services or you can choose to receive Covered health care services from a BCN Network Participating Provider or from an Out-of-Network Non-Participating Provider.

You must select a BCN Primary Care Physician. Your PCP may provide or help coordinate your care for Covered Services.

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

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

- Provided by your Primary Care Physician in the office, in the home or at a Participating Provider – either Inpatient or Outpatient – with any required Preauthorization
- Provided by a Participating Provider with any required Preauthorization, but without coordination with the Primary Care Physician
- Provided by a Non-Participating Provider when there is an insufficient number of Participating Providers for a specific provider specialty within the BCN Service Area. The service must be Preauthorized by BCN for the in-network Cost Share to apply
- Emergency health services
- Urgent care center services
- Provided outside of Michigan utilizing the BlueCard Program (Section 9 Out of Area Services)

NOTE: You are responsible for determining whether a provider is a Participating Provider before obtaining services. This information can be found at bcbsm.com or by contacting Customer Service at the number provided on the back of your BCN ID card. Unless otherwise specified in this Certificate, we pay claims based on the status of the provider as of the date of service.
Out-of-Network Benefits are generally paid at a lower rate than In-Network Benefits or may be excluded from Coverage. You are responsible for the difference between the BCN Approved Amount and the Non-Participating Provider’s charge.

Out-of-Network Benefits are payable for Covered Services that are:
- Provided within the state of Michigan by a Non-Participating Provider
- Preauthorized by BCN if Preauthorization is required under this Certificate
- Provided outside of Michigan without utilizing the BlueCard Program (Section 9 Out of Area Services)

### 8.2 Cost Sharing

#### Deductible

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

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

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

Your Deductible renews each Benefit Year, any Deductible paid during the last 3 months of the prior Benefit Year in which you were enrolled with BCN will not be carried over into the new Benefit Year.

<table>
<thead>
<tr>
<th>DEDUCTIBLE AMOUNT</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100 per individual Member</td>
<td>$100 per individual Member</td>
</tr>
<tr>
<td></td>
<td>$200 per family Contract per Benefit Year</td>
<td>$200 per family Contract per Benefit Year</td>
</tr>
</tbody>
</table>

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

#### Copayment (Copay)

You are responsible for fixed dollar Copays for certain Benefits listed in this Certificate. You are required to pay any Copays at the time you receive the services. Copays count toward your Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum is met, you will not be responsible for Copays for the remainder of the Benefit Year.
Coinsurance
You are responsible for a percentage of the Approved Amount (Coinsurance) for many of the Benefits listed in this Certificate. Your Coinsurance is dependent upon if you receive services in-network or out-of-network. Please refer to the specific section in this Certificate to determine your Coinsurance responsibility.

Coinsurance counts toward your Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, you will not be responsible for Coinsurance for the remainder of the Benefit Year.

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

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

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

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

- Any Premium or contributions paid toward the Premium does not apply to the Out-of-Pocket Maximum.
- Charges paid by you in excess of the Approved Amount do not apply toward the Out-of-Pocket Maximum.
- Services that are not a Benefit under this Certificate do not apply to the Out-of-Pocket Maximum.
- Health Care this Plan does not cover
- Non-authorized Services
- Pediatric dental and vision

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

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,500</td>
<td>$3,500 per individual Member</td>
<td></td>
</tr>
<tr>
<td>$7,000</td>
<td>$7,000 per family Contract per Benefit Year</td>
<td></td>
</tr>
</tbody>
</table>

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

**Benefit Maximum**

Some of the Covered Services described in the Certificate are covered up to a lifetime limit. This is known as the Benefit Maximum. Once you have reached the maximum for a Covered Service, you will be responsible for the cost of the additional services received, even when continued care may be Medically Necessary.

The following Covered Services have a Benefit Maximum:

- Weight reduction procedures
- Travel and lodging for transplant services

**8.3 Balance Bills**

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

**Out-of-Network Benefits**: You are responsible for amounts charged by a Non-Participating Provider that exceed the Approved Amount.

**8.4 Professional Physician Services (Other Than Behavioral Health)**

We cover the following services:

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

- Primary Care Physician (PCP)
- OB/GYN for females
- Specialist physician
- Online Visits
- Eye Care
Office Visit Cost Sharing

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Office Visits:</td>
<td>$20 Copay</td>
<td>20% Coinsurance of the Approved Amount</td>
</tr>
<tr>
<td>Specialist Physician Office Visits:</td>
<td>$20 Copay after In-network Deductible per office visit</td>
<td>after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

**Online Visit**

We pay for Online Visits by a Provider or an online vendor selected by BCN to:
- Diagnose a condition
- Make treatment and consultation recommendations
- Write a prescription, if appropriate
- Provide other medical or health treatment

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

NOTE: Not all Online Visit services are considered an Online Visit but may be considered Telemedicine. Telemedicine services will be subject to the same Cost Sharing as services rendered in an office setting.

<table>
<thead>
<tr>
<th>Online Visit Cost Sharing</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay per Online visit</td>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

For information on how to create an account with a BCN Online Vendor, log into bcbsm.com or see your Member Handbook.

**Online Visit** exclusions include but are not limited to:
- Treatment of Substance Use Disorder
- Reporting of normal test results
- Provision of educational materials
Handling of administration issues, such as registration, scheduling of appointments, or updating billing information.

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

### OFFICE VISIT COST SHARING

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay for each Primary Care Physician office visit</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>$20 Copay after In-Network Deductible for each Specialist visit</td>
<td>Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

**NOTE:** Non-preventive diagnostic, therapeutic and surgical procedures performed in the office are subject to the applicable Deductible, Copayment and Coinsurance.

See Preventive and Early Detection Services section for more information about office visits.

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

### MATERNITY CARE COST SHARING

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routine prenatal visits are covered in full.</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>• Postnatal Visits - $20 Copay per Visit</td>
<td>Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

### HOME VISITS COST SHARING

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
D) **Inpatient Professional Services** when Preauthorized by BCN - while you are in the Inpatient Hospital or Skilled Nursing Facility or Inpatient rehabilitation center and billed by a physician

<table>
<thead>
<tr>
<th>INPATIENT PROFESSIONAL SERVICES COST SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
</tr>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ALLERGY CARE COST SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
</tr>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
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</tbody>
</table>

F) **Chiropractic Services and Osteopathic Manipulative Therapy** when provided by a Chiropractor or Osteopathic Physician

<table>
<thead>
<tr>
<th>CHIROPRACTIC SERVICES COST SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Benefits</strong></td>
</tr>
<tr>
<td>$20 Copay after In-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
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<td></td>
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</tbody>
</table>

**Coverage**

When an office visit and spinal manipulation are billed on the same day by the same In-network Participating Provider, only one Copay will be required for the office visit. Mechanical traction once per day is covered when it is performed with chiropractic spinal manipulation.

Radiological services and X-rays are covered when Preauthorized.
8.5 Continuity of Care for Professional Services

Continuity of Care for Existing Members -match BEPSM

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

**Physician Requirements**

The Continuity of Care provisions apply only when your physician:

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

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

**Medical Conditions and Coverage Time Limits**

- **Pregnancy Related**
  
  If you are in your second or third trimester of pregnancy at the time of the treating physician's disaffiliation, services provided by your physician may continue through post-partum care (typically six weeks) for Covered Services directly related to your pregnancy.

- **Life-threatening condition**
  
  If you have a life-threatening disease or condition for which death is likely if the course of treatment is interrupted. Coverage for services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first.

- **Terminal Illness**
  
  If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the end of the provider's BCN contract, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.

- **Other Medical Conditions**
  
  For Chronic (ongoing) and Acute medical conditions (a disease or condition requiring complex ongoing care such as chemotherapy, radiation therapy, surgical follow-up visits) when a course of treatment began prior to the treating physician's disaffiliation - Coverage for services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first. The treating physician or health care provider must attest that your condition would worsen or interfere with anticipated outcomes if your care were discontinued. Your Participating Primary Care Physician must coordinate all other services in order for them to be Covered Services.
Coverage
If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the “Physician Requirements” listed above, BCN will continue to provide coverage at the In-Network Benefit for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid at the In-Network Benefit Level, your Participating Primary Care Physician must provide or coordinate all such services.

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

Continuity of Care for New Members
If you are a new Member and want to continue an active course of treatment from your existing, Non-Participating Provider, you may request enrollment in BCN’s Continuity of Care program. In order for the services to be paid by BCN at the In-Network Benefit level, at the time of enrollment you must have selected a Primary Care Physician who will coordinate your care with the Non-Participating Provider. You may participate in the Continuity of Care program only for the following conditions and only for the time periods described below.

Coverage Time Limits and Qualification Criteria
- Pregnancy Related
  If you are in your second or third trimester of pregnancy at the time of enrollment, coverage provided by your Non-Participating Provider may continue through post-partum care for Covered Services directly related to your pregnancy.
- Terminal Illness
  If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the Non-Participating Provider related to your illness prior to enrollment, Coverage for services provided by your Non-Participating Provider may continue for the ongoing course of treatment through death.
- Other Medical Conditions
  For Chronic and Acute medical conditions when a course of treatment began prior to enrollment, Coverage for services provided by the Non-Participating Provider may continue through the current period of active treatment or 90 calendar days from the time of enrollment, whichever comes first.

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

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

We cover Preventive and Early Detection Services as defined in the federal Patient Protection and Affordable Care Act (“PPACA”). The services are modified by the federal government from time to time. Preventive Services include but are not limited to the following:

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

Health screenings include but are not limited to:
- Obesity
- Vision and hearing (See Section 9 for exclusions and limitations.);
- Glaucoma
- EKG
- Type 2 diabetes mellitus
- Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

B) Women’s health and well-being

GYNECOLOGICAL (well woman) examinations, including routine pap smear

<table>
<thead>
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BONE DENSITY SCREENING

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<tr>
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</table>
SCREENING FOR SEXUALLY TRANSMITTED DISEASES; HIV counseling and screening

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
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</table>

- Responsible for Balance Billed charges
- Applies toward the Out-of-Network Out-of-Pocket Maximum

MATERNITY COUNSELING for the promotion and support of breast-feeding and prenatal vitamin counseling

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
</tbody>
</table>

- Responsible for Balance Billed charges
- Applies toward the Out-of-Network Out-of-Pocket Maximum

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
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</tr>
</tbody>
</table>

- Responsible for Balance Billed charges
- Applies toward the Out-of-Network Out-of-Pocket Maximum

ROUTINE PRENATAL OFFICE VISITS

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
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<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
</tbody>
</table>

- Responsible for Balance Billed charges
- Applies toward the Out-of-Network Out-of-Pocket Maximum
FEMALE STERILIZATION SERVICES Outpatient and office based

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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. Convenience items such as storage containers, bags, bottles and nipples are not covered. (See Durable Medical Equipment section for limitations and exclusions)

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

CONTRACEPTIVE COUNSELING AND METHODS

- Office administered contraceptive devices and appliances; such as intrauterine devices (IUDs) Implantable and injected drugs such as Depo-Provera
- Diaphragms including measurement, fittings, removal, administration; and management of side effects

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
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<td>✓ Responsible for Balance Billed charges</td>
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<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

SCREENING AND COUNSELING FOR INTERPERSONAL AND DOMESTIC VIOLENCE

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
GENETIC COUNSELING and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes.

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
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</tr>
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<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
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<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Other nutritional counseling services may be covered when Preauthorized by your Physician and BCN.
NOTE: Certain health education and health counseling services may be arranged through your 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

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

<table>
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<tbody>
<tr>
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</tr>
<tr>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
I) Tobacco use and tobacco caused disease counseling

<table>
<thead>
<tr>
<th>In-network Benefits</th>
<th>Out-of-network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

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

8.7 Inpatient Hospital Services

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

- Room and board, general nursing Services and special diets
- Operating and other surgical treatment rooms, delivery room and special care units
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, radiation therapy, inhalation therapy and dialysis
- Physical, speech and occupational therapy
- Long term Acute Care
- Other Inpatient Services and supplies when Medically Necessary
- Maternity care and all related services when provided by the attending physician or Certified Nurse Midwife. The Certified Nurse Midwife must be overseen by an OB/GYN.
Under federal law, the mother is covered for no less than the following length of stay in a hospital in connection with childbirth except as excluded under Section 9.

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

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

NOTE: Maternity Care includes coverage of the mother’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 mother’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 mother’s attending physician
- Routine Care during the newborn’s eligible hospital stay

NOTE: If the newborn is not covered under a BCN contract they may qualify for coverage under the mother’s maternity care benefit for the period of 48 or 96 hours.
**Cost Sharing - Inpatient Hospital Services**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 Copay per admission after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

See Professional Physician Services section for Inpatient Professional Cost Sharing.

**8.8 Outpatient Services**

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

You receive Outpatient Services in these places:
- Outpatient Hospital setting
- Physician office
- Free standing ambulatory setting
- Dialysis center

Outpatient Services include but are not limited to:
- Facility and professional (physician) Services
- Surgical treatment
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, inhalation therapy, radiation therapy and dialysis
- Physical, speech and occupational therapy-see Outpatient Therapy Services
- Injections – for allergy-see Professional Physician Services (Other Than Behavioral Health Services) section
- Professional Services-see Professional Physician Services (Other Than Behavioral Health Services) section
- Durable medical equipment and supplies-see Durable Medical Equipment section
- Diabetic equipment and supplies-see Diabetic Supplies and Equipment section
- Prosthetic and orthotic equipment and supplies-see Prosthetic and Orthotics section
- Other Medically Necessary Outpatient Services and supplies
### Cost Sharing - Facility and Professional Services

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

NOTE: Lab and pathology Services are covered in full.

### Cost Sharing - High Technology Radiology Services

such as MRI, MRA, CAT, PET when Medically Necessary and Preauthorized by BCN

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

### 8.9 Emergency and Urgent Care Definitions

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

- **Emergency Services** - services to treat a Medical Emergency as described below

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

- **Stabilization** - the point at which, it is reasonably probable that no material deterioration of a condition is likely to result from or occur during your transfer

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

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

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

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

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

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

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

Emergency Services Cost Sharing

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75 Copay per visit</td>
<td>$75 Copay per visit</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

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

Admission to Non-Participating Hospital after Emergency Services

If you are hospitalized in a Non-Participating Hospital, we may require that you be transferred to a Participating Hospital as soon as you have Stabilized. If you refuse to be transferred, all related non-Emergency Covered Services will be covered as Out-of-Network Benefits from the date of Stabilization.
Out-of-Area Coverage and Non-Participating Provider Coverage

You are covered when traveling outside of the BCN Service Area for Emergency Services that meet the conditions described above. (See Section 9 and the attached BlueCard Rider for additional information.) For dates of Service beginning on or after 1/1/2020, when Services are rendered by a Non-Participating Provider, we pay the greater of:

- Median in-network rate
- Rate we would pay a Participating Provider
- Medicare rate

These rates are calculated according to the requirements of the Patient Protection and Affordable Care Act.

You are responsible for any Cost Sharing required under this Certificate or amended Rider. Additionally, you will be responsible to pay the difference between BCN’s Approved Amount and the amount the Non-Participating Provider bills if the Non-Participating Provider does not accept BCN’s Approved Amount as payment in full (also referred to as Balance Billing). This amount does not apply to your Out-of-Pocket Maximum.

Urgent Care Services Cost Sharing

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay after In-Network Deductible</td>
<td>$20 Copay after Out-of-Network Deductible</td>
</tr>
<tr>
<td>☑ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>☑ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>☑ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

8.10 Ambulance

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

For ground ambulance, a covered destination may include:

- A hospital
- A Skilled Nursing Facility
- A Member’s home
- A dialysis center

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN
We will pay for a Member to be taken to the nearest destination capable of providing necessary care to treat the Member's condition.

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

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

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

Coverage is also included 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**

Air Ambulance services must also meet these requirements:

- No other means of transport are available
- The Member's condition requires transportation by air ambulance rather than ground ambulance.
- An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.
- The Member is transported to the nearest facility capable of treating the Member's condition.

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

**Non-emergency ground ambulance** services are covered when Preauthorized by your treating physician and BCN.
**Ambulance Cost Sharing**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered – 100% of the Approved Amount after In-Network Deductible</td>
<td>Covered 100% of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

**Exclusions include but are not limited to**

- Transportation or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services provided as part of a response to an accident or emergency situation, like accident clean-up or 911 costs are not a covered benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the Member’s condition does not require air ambulance transport.
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.

**8.11 Reproductive Care and Family Planning**

We cover:
- Non-Elective abortion
- Genetic testing
- Voluntary sterilization
- Infertility

**A) Non-Elective Abortion**

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

### Cost Sharing Non-Elective Abortion

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your In-Network Inpatient and Outpatient benefit applies to non-elective abortion procedures including office consultations</td>
<td>Your Out-of-Network Inpatient and Outpatient benefit applies to non-elective abortion procedures including office consultations</td>
</tr>
</tbody>
</table>

**Exclusions include but are not limited to**
- Any service related to Elective Abortions with the exception of office consultations (See Elective Abortion Rider for Coverage)
- Cases not identified above
- Abortions otherwise prohibited by law

#### B) Genetic Testing

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

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

### Cost Sharing Genetic Testing

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay per PCP office visit</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>$20 Copay after In-Network Deductible per Specialist office visit</td>
<td>Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
<tr>
<td></td>
<td>Lab and pathology Services are covered in full.</td>
</tr>
</tbody>
</table>

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

#### C) Voluntary Sterilization

We cover Inpatient, Outpatient, and office-based sterilization services
Cost Sharing - Female Sterilization

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered – 100% as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Responsible for Balance Billed charges</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Cost Sharing - Male Sterilization

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
<td></td>
</tr>
</tbody>
</table>

Exclusions include, but are not limited to
Reversal of surgical sterilization for males or females

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

Cost Sharing - Infertility

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible for all fees associated with infertility diagnostic work-up procedures, treatment and all facility professional and related services, including select prescription drugs approved by BCN</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible for all fees associated with infertility diagnostic work-up procedures, treatment and all facility professional and related services, including select prescription drugs approved by BCN</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
<td></td>
</tr>
</tbody>
</table>
**Exclusions include but are not limited to**

- Harvesting
- Storage or manipulation of eggs and sperm
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- In-vitro fertilization (IVF) procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related services
- Artificial insemination (except for treatment of infertility)
- All services related to surrogate parenting arrangements including, but not limited to, maternity and obstetrical care for non-member surrogate parents
- Reversal procedures and other infertility services for couples who have undergone a prior voluntary sterilization procedure (e.g. vasectomy or tubal ligation)

**8.12 Skilled Nursing Facility**

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

**Cost Sharing - Skilled Nursing Facility**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 Copay per admission after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Unlimited Days when Preauthorized by BCN

**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)

**8.13 Hospice Care**

Hospice Care is an alternative form of medical care for terminally ill with a life expectancy of 6 months or less. Hospice Care provides comfort and support to Members and their families when a life limiting illness no longer responds to cure oriented treatments.
Hospice Care in a Participating licensed hospice facility, hospital or Skilled Nursing Facility is covered. We also cover Hospice Care in the home. Hospice Care has to be Medically Necessary and Preauthorized by BCN.

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

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

### Cost Sharing - Hospice Care

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospice:</strong></td>
<td></td>
</tr>
<tr>
<td>$150 Copay per admission</td>
<td>Inpatient and Outpatient Hospice:</td>
</tr>
<tr>
<td>after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount</td>
</tr>
<tr>
<td><strong>Outpatient Hospice:</strong></td>
<td>after Out-of-Network Deductible</td>
</tr>
<tr>
<td>$150 Copay per visit</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>after In-Network Deductible</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td></td>
</tr>
</tbody>
</table>

**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

### 8.14 Home Health Care Services

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

Home Health Care must be:
- Medically Necessary
- Provided by a Home Health Care agency
- Provided by professionals employed by the agency and who participate with the agency
We cover the following Services:
- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy
- Hospice Care
- Other health care services approved by BCN when performed in the Member's home

Cost Sharing - Home Health Care Services

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
</tbody>
</table>
| ✓ Applies toward the Out-of-Network Out-of-Pocket Maximum | ✓ Responsible for Balance Billed charges
| ✓ Applies toward the Out-of-Network Out-of-Pocket Maximum |

Exclusions from In-Network and Out-of-Network Benefits include but are not limited to
- Housekeeping services
- Custodial Care (See Section 9)

8.15 Home Infusion Therapy Services

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

Food Supplements

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

Supplemental feedings administered via an IV:
This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

We cover Home Infusion Therapy Services when Medically Necessary and Preauthorized by BCN.
Cost Sharing - Home Infusion Therapy Services

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered -100% after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
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<tr>
<td></td>
<td>Responsible for Balance Billed charges</td>
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<tr>
<td></td>
<td>Applies toward the Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

A. Mental Health Care

We cover evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions that are in accordance with generally accepted standard of practice. Non-Emergency Mental Health services must be Preauthorized as Medically Necessary by BCN with the exception of routine outpatient psychotherapy services. (Mental Health Emergency Services are covered – see Emergency and Urgent Care section.)

Medical services required during a period of mental health admission must be Preauthorized separately by your Primary Care Physician and BCN.

Definitions

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

Residential Mental Health Treatment is treatment that takes place in a licensed domiciliary facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 or available afterhours with a response time of 60 minutes to the facility to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists.

Residential treatment is:
- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program
- A structured environment that will allow the individual to 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”), however, the benefit design will be the same as your medical inpatient benefit when Preauthorized by BCN
Partial Hospitalization Mental Health is a comprehensive acute care program that consists of a minimum of 4 hours per day, at least 3 days per week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluations and other services in a treatment plan. Partial Hospitalization services are often provided in lieu of Inpatient psychiatric Hospitalization.

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

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

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

Cost Sharing

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 Copay per admission after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

In-Network and Out-of-Network Services are covered when determined to be Medically Necessary and Preauthorized by BCN.

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay per visit - no matter the location</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

NOTE: Diagnostic testing, injections, therapeutic treatment and medical services are subject to the medical Outpatient Services Cost Share
NOTE: See Section 9 for exclusions and limitations.

**B. Substance Use Disorder Services**

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

Non-Emergency Substance Use Disorder treatments must be Preauthorized as Medically Necessary by BCN with the exception of routine outpatient psychotherapy services. (Substance Use Disorder Emergency Services are covered – see Emergency and Urgent Care services section.)

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

**Definitions**

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

- **Inpatient Substance Use Disorder Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical Hospitalization. Inpatient services may include 24-hour professional supervision. Services may include counseling, Detox, medical testing, diagnostic and medication evaluation and other services specified in a treatment plan.

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

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

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

- **Intensive Outpatient Substance Use Disorder Treatment** means treatment that is provided on an Outpatient basis consisting of a minimum of 3 hours per day, 3 days per week and might include, but are not limited to, individual, group and family counseling, medical testing, diagnostic and medication evaluation and other services specified in a treatment plan.
• **Outpatient Substance Use Disorder Treatment** means Outpatient visits (for example - individual, conjoint, family or group psychotherapy) for a Member who is dependent on or abusing alcohol or drugs (or both). The visit may include counseling, detoxification, medical testing, diagnostic evaluation and other services.

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

**Cost Sharing - Detox/Inpatient/Partial Hospitalization/Partial Domiciliary Substance Use Disorder**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
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<tbody>
<tr>
<td>$150 Copay per admission after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ When Medically Necessary and Preauthorized by BCN</td>
<td>✓ When Medically Necessary and Preauthorized by BCN</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

**Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td>$20 Copay per visit - no matter the location</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

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

**NOTE:** See Section 9 for exclusions and limitations

**8.17 Autism Spectrum Disorders**

**Definitions**
Applied Behavioral Analysis, or “ABA”, means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct-observation, measurement, and functional analysis of the relationship between environment and behavior.
Approved Autism Evaluation Center ("AAEC") is an academic or Hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the ASD. AAEC evaluation is necessary for ABA. The AAEC must be approved by BCN.

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

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

Line Therapy means tutoring or other activities performed one-on-one with person diagnosed with ASD according to a Treatment Plan designed by a BCN AAEC and a Board Certified Behavioral Analyst (BCBA).

Preauthorization occurs before treatment begins. A BCN nurse or case manager approves the initial Treatment Plan and continued services. A request for continued services will be authorized contingent on the Member demonstrating measurable improvement and therapeutic progress, which can typically occur at 3, 6, or 9-month intervals.

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

Benefits
Services for the diagnosis and treatment of ASD are covered. Covered diagnostic services must be provided by a licensed physician or a licensed psychologist and include assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule.

Note: A BCN approved AAEC must confirm the Member has Autism Spectrum Disorder (ASD) prior to receiving Applied Behavioral Analysis.

We cover
- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's ASD
- Therapeutic care as recommended in the Treatment Plan includes:
  - Occupational therapy, speech and language therapy and physical therapy (when performed by a licensed certified occupational therapist, speech therapist and physical therapist)
  - ABA (when performed by a BCBA licensed psychologist)
  - Outpatient mental health therapy (when performed by a social worker, clinical psychologist and psychiatrist)
  - Genetic testing
- Social skills training
- Nutritional therapy

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

- Services that are deemed experimental or ineffective by BCN are covered only when mandated by law, and included in a Treatment Plan recommended by the BCN AAEC that evaluated and diagnosed the Member’s condition and when approved by BCN

**Coverage**

ABA treatment is available to children through the age of 18. This limitation does not apply to:

- Other mental health Services to treat or diagnose ASD
- Medical Services, such as physical therapy, occupational therapy, speech therapy, genetic testing or nutritional therapy used to diagnose and treat ASD

ABA for Line Therapy In-Network and Out-of-Network is subject to the In-Network Primary Care Physician office visit Copay and Out-of-Network Cost Sharing as defined in this Certificate.

Behavioral health services included in the Treatment Plan are subject to the In-Network Primary Care Physician office visit Copay and Out-of-Network Cost Sharing as defined in this Certificate.

Outpatient therapy services included in the Treatment Plan are subject to the applicable In-Network or Out-of-Network Specialist Cost Sharing as defined in this Certificate.

This Coverage overrides certain exclusions as defined in this Certificate such as

- Exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities
- Treatment solely to improve cognition concentration and attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought for treatment of ASD.

**Benefit Limitations**

Coverage is available subject to the following requirements:

- **Preauthorization** – In-Network and Out-of-Network services performed under the recommended Treatment Plan must be approved for payment during BCN’s Preauthorization. If Preauthorization is not obtained, rendered services will not be covered. The Member may be held responsible for payment for those services

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

• **Required Diagnosis for ABA** – In order to receive Preauthorization for ABA, the Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, Participating developmental pediatrician or other professional as agreed upon by a BCN AAEC. Other Preauthorization requirements may also apply. The requirement to be evaluated and diagnosed by a BCN AAEC does not exist for other services related to ASD.

• **Termination at age 19** – Benefits are limited to children up to and including the age of 18. This age limitation does not apply to Outpatient Mental Health services (excluding applied behavioral analyses services) and services used to diagnose ASD. Benefits for ASD terminate on the child’s 19th birthday.

• **Treatment Plan** – ABA Services must be included in a Treatment Plan recommended by a BCN AAEC that evaluated and diagnosed the Member’s condition
  – Measurable improvement in the Member’s condition must be expected from the recommended Treatment Plan. Once treatment begins, the plan will be subject to periodic assessment by BCN nurse or case manager.

**Exclusions include but are not limited to**

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

**8.18 Outpatient Therapy Services**

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

• Medical rehabilitation – including but not limited to cardiac and pulmonary rehabilitation
• Physical therapy
• Occupational therapy
• Speech therapy
• Cognitive therapy
• Chiropractic and Osteopathic mechanical traction
• Biofeedback for treatment of select medical diagnoses when Medically/Clinically Necessary as determined according to BCN medical policies
Coverage
Short-term Outpatient Therapy Services when meeting the following criteria:

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

Habilitative Services that help a person keep, learn or improve skills and functioning for daily living are covered when Preauthorized by BCN as Medically Necessary.

Examples include but are not limited to:

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

Cost Sharing - Outpatient Therapy Services

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay per visit after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount on all associated costs after</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Unlimited visits when Preauthorized by BCN

General Exclusions include but are not limited to

- Services that can be provided by any federal or state agency or local political subdivision, including school districts, when the Member is not liable for the costs in the absence of insurance
- Vocational rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return to work programs
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency
- Craniosacral therapy
- Prolotherapy
- Rehabilitation services obtained from non-Health Professionals, including massage therapists
• Strength training and exercise programs
• Sensory integration therapy

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

**8.19 Durable Medical Equipment**

Durable Medical Equipment (DME) must be:
• Medically Necessary
• Used primarily for medical purposes
• Prescribed by the treating physician
• Intended for repeated use
• Useful primarily because of illness, injury or congenital defect

**Coverage**

We cover rental or purchase of DME when limited to the basic equipment. Any supplies required to operate the equipment and special features must be Medically Necessary and Preauthorized by BCN. Items are payable when received from an In-Network DME Participating Provider or a Participating facility upon discharge.

In many instances, BCN covers the same items covered by Medicare Part B as of the date of the purchase or rental. In some instances, however, BCN guidelines may differ from Medicare. For specific coverage information and to locate a Participating Provider, please call Customer Service at the number provided on the back of your BCN ID card.

**Cost Sharing - Durable Medical Equipment**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after the In-network Deductible</td>
<td>Not applicable</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
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</tbody>
</table>

**NOTE:** Breast pump needed to support breast-feeding is covered in full in-network (Deductible does not apply). It must be Preauthorized and obtained from a DME Participating Provider or Participating facility upon discharge. (See Preventive and Early Diagnosis section)
Limitations and Exclusions – In-Network Benefits

Limitations include but are not limited to

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

Exclusions include but are not limited to

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

8.20 Diabetic Supplies and Equipment

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

Diabetic Supplies and Equipment must be:
  o Medically Necessary
  o Prescribed by your physician
  o Obtained from a BCN Participating Provider

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

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

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

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

Cost Sharing - Diabetic Supplies and Equipment

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<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after the In-network Deductible</td>
<td>Not applicable</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td></td>
</tr>
</tbody>
</table>

Exclusions include but are not limited to
• Replacement due to loss, theft or damage that can be repaired
Deluxe equipment unless Medically Necessary

If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that is prescribed.

- Alcohol and gauze pads

8.21 Prosthetics and Orthotics

Definitions

- **Prosthetics** are artificial devices that serve as a replacement of a part of the body lost by injury (traumatic) or missing from birth (congenital).
  Prosthetic Devices are either:
  - **External Prosthetic Devices** - Devices such as an artificial leg, artificial arm or the initial set of prescription lenses for replacement of an organic lens of the eye following Medically Necessary eye surgery (e.g. cataract surgery)
  - **Internal Implantable Prosthetic Devices** - Devices surgically attached or implanted during a Preauthorized surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, or implanted lenses immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g. cataract surgery).

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

Coverage

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

Coverage includes but is not limited to the following:

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

In many instances, BCN covers the same items covered by Medicare Part B as of the date of the purchase or rental. In some instances, however, BCN guidelines may differ from Medicare.
For specific Coverage information and to locate a Participating provider, please call Customer Service at the number provided on the back of your BCN ID card.

**Cost Sharing - Prosthetics and Orthotics**

**External Prosthetic Devices and Orthotics**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-network Deductible</td>
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**Internal Implantable Prosthetic Devices**

<table>
<thead>
<tr>
<th>Your Inpatient, Outpatient or office visit Benefit applies</th>
<th>The Cost Sharing applies toward the applicable Out-of-Pocket Maximum</th>
</tr>
</thead>
</table>

**Limitations – In-Network Benefit**

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

**Exclusions include but are not limited to**

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

- Sports-related braces
- Dental appliances, including bite splints
- Hearing aids; including bone anchored hearing devices unless amended by a Rider
- Eyeglasses or contact lenses (except after lens surgery as listed above)
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, wigs and hairpieces
- Over the counter arch supports, foot orthotics
- Shoe inserts that are not attached to leg brace
- Over the counter supplies and disposable supplies such as compression stockings
8.22 Organ and Tissue Transplants

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

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

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 when Preauthorized if the recipient’s health plan does not cover BCN Member donor charges.

Cost Sharing - Organ and Tissue Transplants

<table>
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<tr>
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<tbody>
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<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ When Medically Necessary and Preauthorized by BCN</td>
<td>✓ When Medically Necessary and Preauthorized by BCN</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward Out-of-Network Out-of-Pocket Maximum</td>
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</tbody>
</table>

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

- Community wide searches for a donor
Transplant Travel and Lodging
We also cover eligible travel and lodging during the initial transplant surgery. Covered benefits will be reimbursed by BCN.

- Cost of transportation to and from the recipient’s home and the approved transplant facility for the recipient and another person eligible to accompany the recipient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor).

  Note: In some cases, we may pay for return travel to the original transplant facility if you have an acute rejection episode. The episode must be emergent and must fall within the benefit period. The cost of travel must still fall under the $10,000 maximum for travel and lodging.

- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient. “Lodging refers to a hotel or motel.

Limitations
- Up to $10,000 for eligible travel and lodging during the initial transplant surgery
- Maximum payable $50 per night for lodging per recipient
- Maximum payable $50 per night for lodging per companion

You will not be reimbursed for your travel and lodging expenses unless we have approved for the transplant surgery. In order to be reimbursed for your expenses, you will need to provide itemized paid receipts.

Exclusions
Exclusions include but are not limited to:

- Travel and Lodging costs incurred after the initial transplant surgery and hospitalization beyond episode of care, excluding the rejection episode.

- Additional travel (mileage) is not reimbursable for the same date as a paid lodging receipt. (i.e., if a caregiver travels home during the week and maintains a place of lodging for the same week, only the lodging is reimbursable)

- Transportation and lodging costs for circumstances other than those related to the transplant surgery and hospitalization. Items that are not considered to be directly related to travel and lodging. Examples include:
  - Alcohol beverages
  - Car maintenance
  - Clothing and toiletries
  - Dry cleaning or laundry services
  - Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services
  - Furniture rental
  - Household products
✓ Household utilities (including cellular telephones)
✓ Kennel fees
✓ Lost wages
✓ Maids, babysitters or day care services
✓ Mortgage or rent payments
✓ Reimbursement of food stamps
✓ Security deposits, cash advances
✓ Services provided by family members

8.23 Reconstructive Surgery

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

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

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

Cost Sharing - Reconstructive Surgery

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✔ When Medically Necessary and Preauthorized by BCN</td>
<td>✔ When Medically Necessary and Preauthorized by BCN</td>
</tr>
<tr>
<td>✔ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✔ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✔ Applies toward the Out-of-Network out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
A) **Reduction mammoplasty** (breast reduction surgery) for females when it is Medically Necessary and Preauthorized by BCN

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services</td>
</tr>
<tr>
<td>✓ Applies toward In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
</tbody>
</table>

8.24 **Oral Surgery**

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

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

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

**NOTE:** If performed Inpatient, Inpatient Benefit will apply.
Cost Sharing - Oral Surgery

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Share will apply according to the place where the</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible for professional, Facility and related services when performed in an Outpatient setting</td>
</tr>
<tr>
<td>Service is received.</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Exclusions include but are not limited to

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

See Section 9 for additional exclusions and limitations.

8.25 Temporomandibular Joint Syndrome (TMJ) Treatment

Definition

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

Coverage

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

- Primary Care Physician and specialty office visits for medical evaluation and treatment
- X-rays of the temporomandibular joint, including contrast studies
- Surgery to the temporomandibular joint including, but not limited to, condylectomy, meniscectomy, arthrotoomy and arthrocentesis

Cost Sharing TMJ Treatment

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services</td>
</tr>
</tbody>
</table>
Applies toward the In-Network Out-of-Pocket Maximum

Responsible for Balance Billed charges

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

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

Important: Dental services are not covered under this Certificate. See your dental certificate for additional coverage.

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

8.26 Orthognathic Surgery

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

Coverage
We cover Medically Necessary Services listed below when Preauthorized by BCN:

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

Cost Sharing Orthognathic Surgery

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible of all fees associated with Facility, professional and related services</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related services</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
Exclusions include but are not limited to

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

8.27 Weight Reduction Procedures

We cover weight reduction procedures and surgery when determined to be Medically Necessary and Preauthorized by BCN. You must meet the BCN medical criteria and the established guidelines related to the procedure.

Cost Sharing - Weight Reduction Procedures

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible of all fees</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees</td>
</tr>
<tr>
<td>associated with Facility, professional and related services for all weight reduction</td>
<td>associated with Facility, professional and related services for all weight reduction</td>
</tr>
<tr>
<td>procedures</td>
<td>procedures</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Benefit Maximum

Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary as determined by BCN. The lifetime limit is combined In and Out-of-Network.

8.28 Prescription Drugs and Supplies

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

A) Prescription Drugs Received while you are an Inpatient

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

B) Cancer Drug Therapy

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

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

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

**Cost Sharing**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Drug Therapy - Covered in full</td>
<td>Cancer Drug Therapy - Covered in full</td>
</tr>
<tr>
<td>Cost of administration - 10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>Cost of administration - 20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
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</tbody>
</table>

Coordination of Benefits for cancer therapy drugs: Your BCN Prescription Drug Rider will cover drugs for cancer therapy that are self-administered first before Coverage under this Certificate will apply.

**C) Injectable Drugs**

The following drugs are covered as medical benefits:
• Injectable and infusible drugs administered in a Facility setting
• Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or Outpatient Facility

We may require selected Drugs be obtained through a BCN approved designated supplier. BCN will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting.

Selected injectable drugs in certain categories and drugs that are not primarily intended to be administered by a Health Professional are covered by your BCN Prescription Drug Rider attached to this Certificate.

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

• Drugs not approved by the FDA
• Drugs not reviewed or approved by BCN
• Experimental of investigations 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:
8.29 Clinical Trials

Definition

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

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

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

- **Phase I**: Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients.

- **Phase II**: The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety.

- **Phase III**: If a treatment has shown to be effective in Phase II, it is subjected to additional scrutiny in Phase III. In this phase, the sample size of the study population is increased to between 1,000 and 3,000 people. The goals in Phase III are to confirm the effectiveness noted in Phase II, monitor for side effects, compare the study treatment against current treatment protocols, and collect data that will facilitate safe use of the therapy or treatment under review.

- **Phase IV**: These studies are done after the drug or treatment has been marketed or the new treatment has become a standard component of patient care. These studies continue testing the study drug or treatment to collect information about their effect in various populations and any side effects associated with long-term use. Phase IV studies are required by the FDA when there are any remaining unanswered questions about a drug, device or treatment.

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

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
Qualified Individual means a Member eligible for Coverage under this Certificate who participates in an Approved Clinical Trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

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

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

Coverage

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

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

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

Limitations and exclusions include but are not limited to

- The Experimental or Investigational item, device or Service itself
- Experimental treatment or Services related to Experimental treatment except as explained under “Coverage” above
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member
• A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
• Administrative costs related to Experimental treatment or for research management
• 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

8.30 Gender Dysphoria Treatment

Definition
Gender Dysphoria
A broad diagnosis that covers a person’s emotional discontent with the gender they were assigned at birth. A clinical diagnosis is made when a person meets the specific criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

Coverage
We cover services for the treatment of Gender Dysphoria when determined to be Medically Necessary and, Preauthorized by BCN. The Provider must supply documentation supporting that you meet the BCN medical criteria and established guidelines.

Cost Sharing
Your Inpatient and Outpatient In-Network or Out-of-Network Benefit Cost Sharing applies including office consultations as defined in this Certificate and attached Riders.

Exclusions include but are not limited to
• Gender reassignment services that are considered cosmetic
• Experimental or investigational treatment
8.31 Adult Vision Exam

**Routine Vision Exam** - performed by an optometrist, ophthalmologist or other provider to determine refractive error and to issue a prescription for corrective lenses. Note: for pediatric vision coverage, see attached pediatric vision rider.

Adult Vision Coverage includes the following:

- Up to 2 vision exams per Member per Benefit Year
- One office visit for the fitting of prescription contact lenses per Member per Benefit Year

**Cost Sharing Adult Vision Exam**

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay per Visit</td>
<td>20% Coinsurance of the Approved Amount</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

**Exclusions include but are not limited to**

Dilation, frames, lenses and contact lenses
Section 9: Exclusions and Limitations

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

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

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

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

9.4 Non-Covered Services
We do not pay for these services:
- Services that do not meet the terms and guidelines of this Certificate
- Office visits, exams, treatments, tests and reports for any of the following
  - Employment
  - Insurance
  - Travel (immunizations for purposes of travel or immigration are a covered benefit)
  - Licenses and marriage license application
    Legal proceedings such as parole, court and paternity requirements
  - School purposes, camp registration or sports physicals
  - Educational and behavioral evaluations performed at school
  - Completion or copying of forms or medical records, medical photography charges, interest on late payments and charges for failure to keep scheduled appointments
- Expenses of travel and transportation or lodging, except for covered Ambulance services and transplant 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 cord blood bank or other facility without immediate medical indication
• Testing to determine parentage
• Services performed by a provider with your same legal residence
• Services performed by a provider who is a family member
• Food, dietary supplements and metabolic foods
• Private duty nursing
• Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
• Services outside the scope of practice of the servicing provider
• Late fees
• All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
• Psychoanalysis and open-ended psychotherapy
• 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
• Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment
• Treatment programs that have predetermined or fixed lengths of care
• Court ordered examinations, tests, reports or treatments that do not meet requirements for Mental Health or Substance Use Disorder Coverage such as treatment of or programs for sex offender or perpetrators of sexual or physical violence
• Marital counseling services
• Religious oriented counseling provided by a religious counselor who is not a Participating Provider
• Services to hold or confine a person under chemical influence when no medical services are required
• The costs of a private room or apartment
• Non-medical services including enrichment programs like
  • Dance therapy
  • Art therapy
  • Equine therapy
  • Ropes courses
  • Music therapy
  • Yoga and other movement therapies
  • Guided imagery
• Consciousness raising
• Socialization therapy
• Social outings and education/preparatory courses or classes

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

We do not pay for cosmetic surgery including but not limited to:
• Elective rhinoplasty
• Spider vein repair
• Breast augmentation
• Any related service such as pre-surgical care, follow-up care and reversal or revision of surgery is not covered.

9.6 Prescription Drugs
We do not pay for the following drugs:
• Outpatient prescription drugs. These are covered under your prescription drug Rider.
• Over-the-counter drugs or products
• Any medicines incidental to Outpatient care except as defined in Section 8

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

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

9.9 Comfort Items
We do not pay for comfort or convenience items:
• Personal comfort items
• Convenience items
• Telephone
• Television or similar items
9.10 Court Related Services
- We do not cover court ordered services including but not limited to pretrial and court testimony, court-ordered exams or the preparation of court-related reports that do not meet health care coverage requirements.
- We do not cover court-ordered treatment for substance use disorder or mental illness except as specified in Sections 8.
- We shall not be liable for any loss to which a contributing cause was the Member’s commission of or attempt to commit a felony or to which a contributing cause was the Member’s engagement in an illegal occupation.

9.11 Elective Procedures
We do not pay for elective procedures:
- Reversal of a surgical sterilization.
- In vitro fertilization (IVF) procedures, such as GIFT (gamete intrafallopian transfer) or ZIFT (zygote intrafallopian transfer) and all related services.
- Artificial insemination except for treatment of infertility.
- Genetic testing and counseling for non-members for any purpose.

9.12 Maternity Services
We do not pay for these maternity services:
- 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 mother is not covered under this Certificate on the newborn’s date of birth.
  - The newborn is covered under a BCN contract or other health care benefit plan on his or her date of birth.
  - The Subscriber directs BCN not to cover the newborn’s services.
  - Services provided to the newborn occur after the 48 or 96 hours defined under the mother's maternity care benefit.

9.13 Dental Services
We do not pay for the following dental services under this Certificate. Please see your dental Certificate for applicable Coverage.
- Routine dental services and procedures.
- Diagnose or treatment of dental disease.
- Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.
- Restoration or replacement of teeth.

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

9.14 Services Covered Through Other Programs
We do not pay for services covered through other programs:
- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or Certificate
- Under any other policy, program, contract or insurance as stated in General Provisions, Section 2 “Other Party Liability” (The General Provisions is the chapter that describes the rules of your health care coverage.)
- Under any public health care, school, or public program supported totally or partly by State, Federal or Local governmental funds, except where BCN is made primary by law
  The following are excluded to the extent permitted by law:
  - Services and supplies provided in a Non-Participating Hospital owned and operated by any Federal, State or other governmental entity
  - Services and supplies provided while in detention or incarcerated in a facility such as youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment
- Services and supplies under any contractual, employment or private arrangement, (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or Hospital services
- 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
Alternative treatments are not used in standard Western medicine. It is not widely taught in medical schools. We do not pay for alternative services.
Services include but are not limited to:
- Acupuncture
- Hypnosis
- Biofeedback
- Herbal treatments
- Massage therapy
- Therapeutic touch
- Aromatherapy
- Light therapy
- Naturopathic medicine (herbs and plants)
- Homeopathy
- Yoga
- Traditional Chinese medicine

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

9.16 Vision Services
We do not pay for vision services:
- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Refractions, unless Medically Necessary
- Glasses, frames and contact lenses except as defined in the Certificate
- Dilation
- Visual training or visual therapy for learning disabilities such as dyslexia

9.17 Hearing Aid Services
We do not pay for hearing aids, services or items unless a Rider is attached to your Certificate:
- 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 tests or exams to determine what type of hearing aid to prescribe to compensate for loss of hearing
- Hearing aid(s) to amplify sound and improve hearing Bone anchored hearing devices or surgically implanted bone conduction hearing aid
- Conformity evaluation test to verify receipt of the hearing aid, evaluate its comfort, function and effectiveness or adjustments to the hearing aid

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

Services received outside of Michigan are administered through BlueCard®, a Blue Cross® and Blue Shield® Association program. Please refer to the attached BlueCard Rider for specific details on how services are paid. It tells you what you must pay under the exclusions and limitations of this Rider.
Non-routine elective services provided through BlueCard must be Preauthorized by BCN and must follow all BCN Coverage provisions.

In addition to urgent and emergent, services received out-of-country includes routine and follow up care.

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

**Worldwide Travel Assistance Services**

BCN has contracted with GeoBlue to provide coverage for Medical Evacuation, Repatriation of Remains and Bedside Visits. These Benefits are underwritten by BCS Insurance Company. For Coverage information please contact BCS Insurance Company at: 800-621-9215
We speak your language
If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgeti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiamate il 877-469-2583, TTY: 711 se non sei ancora membro.

如果您，或是您正在协助的对象，需要协助，您有权利免费以您的母语得到帮助和讯息。要咨询一位翻译员，请拨打您的卡背面的客户服务电话：如果您还不是会员，请拨打电话 877-469-2583, TTY: 711。

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thể thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thợ dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nése ju, ose dukhese që po ndihmë, ka nevoie për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjihen tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse që vi chura fillë është një tërët më tënë.

如果必要或者有各种原因，您有权得到帮助，您可以要求一位翻译员帮助，您有权得到援助和信息，无需付费。如有需要，请拨打客户服务电话 877-469-2583, TTY: 711。


Important disclosure
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. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide 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.

BLUE CARE NETWORK
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PEDIATRIC VISION COVERAGE RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as set forth below.

A. DEFINITIONS:

1. CONTACT LENSES are prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the patient’s eye.

2. FRAMES are standard frames into which two lenses may be fitted.

3. IN-NETWORK PROVIDER is an ophthalmologist, optometrist or retailer that has a signed agreement to provide services through this coverage. In-Network providers have agreed to accept our approved amount as payment in full for covered services provided under this coverage.

4. LENSES are glass or plastic lenses prescribed by an ophthalmologist or optometrist to correct or improve vision. They are fitted into frames.

5. OPHTHALMOLOGIST is a licensed doctor of medicine or osteopathy who, within the scope of his or her license, performs eye exams and prescribes corrective lenses.

6. OPTOMETRIST is a person licensed to practice optometry in the state the service is provided.

7. OUT-OF-NETWORK PROVIDER is an Ophthalmologist, optometrist, optician or retailer that has not signed an agreement to provide services under this coverage. Out-of-Network providers have not agreed to accept the approved amount as full payment for covered services.

8. PROVIDER is an Ophthalmologist, or Optometrist who provides services related to vision care.

B. ELIGIBILITY:

- Individuals who are under the age of 19 are eligible to be enrolled in pediatric vision coverage if they are enrolled in a medical plan with BCN.

- To obtain coverage, an application must be completed by the parent, legal guardian or someone who is legally authorized to sign a contract on the child's behalf, when the child is a dependent of a group member. An individual who is a member of the group (e.g., someone 18 years of age who is employed by the group) will be required to submit his/her own competed application.

- We will review the application to determine if the individual is eligible for coverage. This determination is based on the terms of the individual's benefit plan, which includes your Certificate of Coverage and this Rider.

- Any individual under the age of 19 who is enrolled in the medical plan will receive Pediatric Vision Benefits through the last day of the year in which they turn age 19 as defined by the Affordable Care Act.

- If the medical plan is terminated or if the individual under age 19 is removed from the medical plan, vision benefits under this Rider will cease for that individual.

C. COST:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>Your copayment is $0</td>
</tr>
<tr>
<td>Prescription Glasses</td>
<td>Your copayment is $0 for both lenses and frames</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>• Your copayment is $0 for medically necessary contact lenses (see Section D for the criteria for medically necessary contact lenses).</td>
</tr>
<tr>
<td></td>
<td>• No copayment is required for prescribed contact lenses that are not medically necessary.</td>
</tr>
<tr>
<td>In-Network Providers</td>
<td>Routine eye examinations, standard lenses and frames, and contact lenses are fully covered (within plan limitations) when obtained from an in-network provider. If the lenses and frames you select are more expensive than the standard lenses and frames described in Section D, you are responsible for the difference in cost.</td>
</tr>
</tbody>
</table>
An in-network provider may bill you when:

- You receive a service not covered by your contract
- We deny a claim from an in-network provider that was submitted more than 180 days after the service because you did not furnish needed information

Out-of Network Providers

We pay our approved amount for exams, lenses and frames and prescribed contact lenses obtained from out-of-network providers. The amount billed by an out-of-network provider may be more than our approved amount and the amount we pay for vision care services is reviewed and adjusted annually. To find out the current amount, contact VSP (see section E)

You should expect to pay charges to an out-of-network provider at the time you receive services. You should then submit a claim. If it is approved payment will be sent to you. See section E: How to reach VSP for the address to send claims.

D. COVERAGE:

Frequency

We pay for:

- One eye exam per calendar year
- One pair of lenses, with or without frames, or contact lenses per calendar year.
- One set of frames per calendar year

Eye Exam

We pay for an eye exam by an ophthalmologist or optometrist. The exam must include the following:

- History
- Testing of visual acuity
- External exams of the eye
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary
Summary of findings

**Lenses**

We pay for standard lenses when prescribed and dispensed by an ophthalmologist or optometrist.

- Lenses may be molded or ground, glass or plastic
- Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standard of the American National Standards Institute.
- The lenses may be colorless or have Rose tints #1 or #2 if therapeutically necessary.
- The lens blank of a standard lens must not exceed 60 mm in diameter. The provider may charge you the difference in cost between standard and oversize lenses.
- If only one lens is needed, we pay half the amount we pay per pair.

We pay for the following special lenses:

- Myodisc
- Lenticular myodisc
- Lenticular aspheric myodisc
- Aphakic
- Lenticular aphakic
- Lenticular aspheric aphakic
- Polycarbonate lenses for children through 18 years of age

We do not pay for aphakic lenses for aphakia (lack of natural lens). These may be covered by your hospital-medical-surgical plan.

We pay for prism, slab-off prism and special base curve lenses when medically necessary.

**Covered Lens Options**

We pay for:

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CF 13243 January 2017 PVS
Disposition Date: 10/11/2016
- Polycarbonate Lenses
- Ultraviolet Protective Coating
- Anti-Reflective Coating
- Blended Lenses
- Progressive Lenses
- Photochromatic Glass Lenses
- Plastic Photo-sensitive Lenses (Transitions®)
- Polarized Lenses
- Intermediate Vision Lenses
- Hi-Index Lenses
- Tints

Frames

Frames chosen from a select collection are covered in full.

Contact Lenses

Suitability Exam – A contact lens suitability exam determines whether you can wear contact lenses. The fee for this exam is covered in full for members when contact lenses are selected. The exam may include:

- Biomicroscopic evaluation
- Lid evaluation
- Ophthalmoscopy
- Tear test
- Pupil evaluation
- Fluorescein evaluation
- Cornea evaluation
- Lens tolerance tests

Medically necessary contact lenses – Contact lenses are considered medically necessary if:

- They are the only way to correct vision to 20/70 in the better eye or
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular curvature

If prescription contact lenses are not needed for the above reasons, members may elect one of the following quantities of lenses as covered in full:

- Standard (one pair annually) - 1 contact lens per eye (total of 2 lenses)
- Monthly (six-month supply) - 6 contact lenses per eye (total of 12 lenses)
- Biweekly (six-month supply) = 12 contact lenses per eye (total of 24 lenses)
- Dailies (two-month supply) = 60 contact lenses per eye (total of 120 lenses)

We do not pay for cosmetic contact lenses that do not improve vision.

E. EXCLUSIONS:

We do not pay for the following:

- Medical-surgical treatment
- Medications administered during any service except an eye exam
- Services or eyewear ordered before coverage began
- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, aniseikonic lenses and tonography
- Replacement of broken or lost lenses or frames
- Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or for which no charge would be made in the absence of BCN coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor quality services
- Medically unnecessary services, glasses or contact lenses
- Experimental or investigational services. We do not pay for a service, procedure, treatment, device, drugs or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient’s condition. In addition, we do not pay
for administrative costs related to experimental treatment or for research management.

- We do not pay additional charges for:
  
  - Lenses tinted darker than Rose tint #2 (such as sunglasses)
  - Oversize lenses (61 mm and larger)
  - Cosmetic lenses/processes
  - Two pair of glasses instead of bifocals

F. HOW TO REACH VSP:

If you have questions about your vision coverage, call VSP at:

1-800-877-7195

Or visit VSP online at www.vsp.com.

Send claims for services of out-of-network providers to:

VSP Claim Services
P.O. Box 385018
Birmingham, AL 35238-5018

G. GENERAL PROVISIONS:

1. A monthly premium rate is charged to the Group for this Rider in addition to the premium charged for the Certificate. The applicable rate is specified on the schedule attached to the Group Agreement and Group agrees to remit to BCN the Rider premium due, including the Subscriber contribution, if any, along with and on the same date as its regular Certificate premium.

2. In the event a Member’s coverage under the Group Member Certificate terminates, this Rider will terminate automatically without further action or notice by BCN.

3. Until further notice, all terms, limitations, exclusions and conditions of the Member Certificate remain unchanged except as provided in this Rider.
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DOMESTIC PARTNER RIDER
(Same and Opposite Gender)
INCLUDING DEPENDENT CHILDREN

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as follows:

1. An adult same or opposite gender Domestic Partner of the Subscriber is eligible for Membership as a Domestic Partner under the Certificate of Coverage if all of the following conditions are met:
   a) Both partners are 18 years of age or older;
   b) The parties are not related by blood in a manner that would prohibit legal marriage;
   c) Neither the Subscriber nor the Domestic Partner was legally married on the date they enrolled for Coverage under this Rider.
   d) The Subscriber and Domestic Partner are each other's sole Domestic Partner, intend to reside together permanently and have resided together for at least twelve consecutive months prior to enrollment in Blue Care Network.

   NOTE: Shared residency may be established by:
   • Driver's license
   • Voter registration
   • Student identification
   • City or county registration
   • Rental or mortgage agreement
   • Other certain document
   e) The Subscriber's employer gives BCN a signed and notarized Affidavit of Domestic Partnership along with the Subscriber's application.

2. The children of Subscriber's Domestic Partner are eligible for Coverage under the Subscriber's contract. They are covered through the end of the Calendar Year in which they turn age 26.
   a) The children must be related to the Domestic Partner by:
      • Birth
      • Legal adoption or
- Legal guardianship

The following are not eligible for Coverage under the Subscriber’s contract:
- The spouse of a Domestic Partner’s child
- The grandchildren of the Domestic Partner (unless eligible under legal guardianship)

b) Disabled, unmarried children of the Subscriber’s Domestic Partner may remain on the Subscriber’s contract after the end of the Calendar Year in which they turn age 26 if all of the following apply:
- 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

Physician certification, verifying the child’s disability and that it occurred prior to the child’s 26th birthday, must be submitted to BCN within 31 days of the end of the Calendar Year in which the Dependent Child turns 26.

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

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

3. This Rider shall terminate automatically at any time the Domestic Partner ceases to meet the eligibility standards of Paragraph 1 above or at any time Coverage of the Subscriber terminates under the Certificate.

4. The Subscriber agrees to notify its Group and BCN within 31 days of any change in eligibility status of any Domestic Partner covered under this Rider. The Subscriber and Domestic Partner will be responsible for reasonable charges for any Services or Benefits provided under the Certificate of Coverage after the Domestic Partner ceases to be eligible for Coverage pursuant to the terms of this Rider.

EFFECTIVE DATE

Coverage takes effect 90-days after the date that the application is approved. However, BCN will waive the 90-day waiting period in the following situations:

- In instances where the Domestic Partner (or the Domestic Partner and his or her children) had Coverage with the Group’s former insurer, BCN will waive the 90-day waiting period at the initial enrollment of the Group, if all of the following conditions are met:
The Domestic Partner can demonstrate that he or she (or the Domestic Partner and his or her children) had Coverage under the Group’s prior health insurance carrier for at least 90-days prior to the effective date of the BCN Coverage.

The Group waives the 90-day waiting period.

The Domestic Partner (or the Domestic Partner and his or her children) meets all other eligibility requirements in this Rider, including the completion of a signed and notarized Affidavit of Domestic Partnership.

The application for Coverage submitted by the Group includes documentation that all of the above are met.

NOTE: The waiver only applies to Domestic Partnerships that exist when BCN Coverage becomes effective. Domestic Partnerships that occur after the effective date of the BCN Coverage will be subject to the 90-day waiting period, along with all other provisions of this Rider.

In instances where the Domestic Partner (or the Domestic Partner and his or her children) has lost eligibility for Coverage under another health care plan, BCN will comply with special enrollment requirements in the Health Insurance Portability and Accountability Act and waive the 90-day waiting period if the following conditions are met:

- The application submitted to BCN by the Group must include a letter or other documentation from the Domestic Partner’s former employer or insurance carrier verifying that the Domestic Partner is no longer eligible for Coverage.
- The Domestic Partner (or the Domestic Partner and his or her children) must meet all other eligibility requirements in this Rider, including completion of a signed and notarized Affidavit of Domestic Partnership.

CHANGES IN YOUR FAMILY

For additional eligibility criteria, please refer to General Provisions chapter within your Certificate of Coverage.

LIMITATIONS AND EXCLUSIONS

- Only one Domestic Partner may be covered under a Subscriber’s contract at one time.
- The Domestic Partner’s Coverage will end if the partnership ends.
- Coverage for children of the Domestic Partner will end if the partnership ends.
- Children of the Domestic Partner will not be covered unless the Domestic Partner is covered under the Subscriber’s contract.
- Coverage for the Domestic Partner and his or her children will end if the Subscriber’s coverage ends.
- Coverage will end if any statement in the Affidavit of Domestic Partnership or any other documents given to us is false when it is submitted or becomes false after that.

- Domestic Partners are not eligible for surviving spouse Coverage when this option is available under the Subscriber's contract.

GENERAL PROVISIONS

1. In the event a Member's Coverage under the Certificate of Coverage terminates this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.
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UNIVERSITY OF MICHIGAN
VOLUNTARY ABORTION COVERAGE RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as set forth below.

Coverage is added for voluntary first trimester termination of pregnancy (up to the end of the 13th week of pregnancy) in each two-year period of membership. Voluntary first trimester termination of pregnancy is a covered benefit with the following Coinsurance:

<table>
<thead>
<tr>
<th>Voluntary Abortion</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10% Coinsurance of the Approved Amount</td>
<td>10% Coinsurance of the Approved Amount</td>
</tr>
<tr>
<td>✓ Deductible does not apply</td>
<td>✓ Deductible does not apply</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

All the provisions in your Certificate and related Riders are unchanged except as stated in this Rider.
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UNIVERSITY of MICHIGAN STUDENT HEALTH PLAN
HEARING AID RIDER with INTEGRATED DEDUCTIBLE
10% In-Network/20% Out-of-Network

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate of Coverage as set forth below.

DEFINITIONS
Approved Amount is the lower of the billed charge or the maximum payment level that BCN will pay for a Covered Service.

Audiologist is a professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems. They may dispense and fit hearing aids as part of a comprehensive rehabilitative program.

Audiometric Hearing Aid Examination is a procedure to evaluate hearing and measure hearing loss. The examination includes:

- Tests for measuring hearing acuity relating to air conduction
- Bone conduction
- Speech reception threshold and speech discrimination
- Summary of findings

Binaural Hearing Aids are two electronic devices (one set) delivered on the same day worn by the patient to amplify sound and improve hearing in both ears.

Bone Anchored Hearing Aid is a bone conduction Hearing Aid composed of a titanium screw that is surgically implanted in the temporal bone behind the ear.

Conformity Evaluation Test is a follow-up visit to the physician specialist, Audiologist or Hearing Aid Dealer who prescribed the Hearing Aid to verify receipt of the prescribed Hearing Aid and evaluate its comfort, function and effectiveness. Necessary adjustments are made to assure optimal amplification and performance.

Deductible is the amount that you must pay first before BCN will pay for covered Hearing Aid services under this Rider. Your Deductible is defined in your Certificate of Coverage and this Rider. The Deductible applies to your Out-of-Pocket Maximum.
Ear Mold is a device made of soft rubber, plastic, or non-allergenic materials, vented or non-vented, that is fitted to the outer ear canal and pinna of the patient.

Hearing Aid is an electronic device worn to amplify sound and improve hearing. A conventional Hearing Aid (Monaural or Binaural) is a basic adjustable Hearing Aid that fits inside the ear, behind the ear, or on the body. A Hearing Aid may also include an Ear Mold or a Bone Anchored Hearing Aid, if determined to be Medically Necessary in accordance with BCN medical policy.

Hearing Aid Dealer is a specialist who is licensed to perform:
- Audiometric Examinations,
- Hearing Aid Evaluation Tests,
- Conformity Evaluation Tests and
- to sell prescribed Hearing Aids.

Hearing Aid Evaluation Test determines what type of Hearing Aid should be prescribed to compensate for loss of hearing, based on the results of the Audiometric Exam.

Monaural Hearing Aid is a single electronic device worn to amplify sound and to improve hearing in one ear.

BENEFITS

Benefits as described in your Certificate of Coverage are amended to include Audiometric Hearing Aid Examination or Hearing Aid Evaluation, Conformity Evaluation test and conventional monaural or binaural Hearing Aids.

A Bone Anchored Hearing Aid is also a Covered Benefit if, in accordance with BCN medical policy, the conventional Hearing Aid does not appropriately treat a Member’s medical need, and, pursuant to BCN medical necessity criteria and policy, the Bone Anchored Hearing Aid is necessary therapeutic alternative to the conventional Hearing Aid. Bone Anchored Hearing Aid must be preauthorized by BCN.

NOTE: A hearing screening performed by your Physician is covered under your Certificate of Coverage.

Hearing care services must be authorized and performed by a Provider, or Audiologist. The Hearing Aid must be dispensed by a Provider (Hearing Aid Dealer or specialist).

Coverage is provided under this Rider only after 6 to 24 months have elapsed since the previous Audiometric Hearing Aid Examination, Hearing Aid Evaluation, Conformity Evaluation and the dispensing of a conventional Monaural Hearing Aid or Binaural Hearing Aids.
Coverage is provided under this Rider after you pay your plan Deductible and only after 6 to 24 months have elapsed since the previous Audiometric Hearing Aid Examination, Hearing Aid Evaluation, Conformity Evaluation Test and the dispensing of a conventional Monaural Hearing Aid or Binaural Hearing Aids.

NOTE: Your Deductible is integrated, meaning your covered medical, prescription drugs, and Hearing Aid service costs are combined to satisfy the overall plan Deductible. Once the plan In-Network or Out-of-Network Deductible is met, you are responsible for the In-Network or Out-of-Network Coinsurance up to the In-Network or Out-of-Network Out-of-Pocket Maximum. You are also responsible for any costs over the Approved Amount designated by BCN for the different type of Hearing Aid that may be prescribed or dispensed. Any cost over the Approved Amount does not apply to the Out-of-Pocket Maximum.

The Approved Amount for conventional aids may be applied toward the price of non-conventional Hearing Aids at the Subscriber's option.

The integrated Deductible and Out-of-Pocket Maximum amounts are defined in your Certificate of Coverage and this Rider. Once you reach the defined Out-of-Pocket Maximum for Covered Services, your Covered Services are covered in full.

**COST SHARING**

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$100 per Member</td>
<td>$100 per Member</td>
</tr>
<tr>
<td></td>
<td>$200 per Contract per Benefit Year</td>
<td>$200 per Contract per Benefit Year</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$3,500 per Member</td>
<td>$3,500 per Member</td>
</tr>
<tr>
<td></td>
<td>$7,000 per Contract per Benefit Year</td>
<td>$7,000 per Contract per Benefit Year</td>
</tr>
<tr>
<td><strong>Hearing Aid Exams</strong></td>
<td>10% Coinsurance of the Approved Amount after In-network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>10% Coinsurance of the Approved Amount after In-Network Deductible</td>
<td>20% Coinsurance of the Approved Amount after Out-of-Network Deductible</td>
</tr>
<tr>
<td></td>
<td>✓ Applies toward the In-Network Out-of-Pocket Maximum</td>
<td>✓ Responsible for Balance Billed charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>
Hearing Aid Maximum per ear

One hearing aid per ear every 6-24 month consecutive period per Benefit Year.

NOTE: If you use both In-Network and Out-of-Network Benefits, separate Deductible and Out-of-Pocket Maximum amounts apply. The Deductible and Out-of-Pocket Maximums for In-Network and Out-of-Network Benefits are not combined to satisfy the Deductible or Out-of-Pocket Maximum limits.

EXCLUSIONS

Exclusions include but not limited to:

- Replacement of Hearing Aids that are lost or broken, unless you have not used this benefit in the previous 6-24 months.
- Eye-glass type Hearing Aids. Cosmetic services or equipment.
- Replacement parts including batteries, maintenance, repairs and insurance expenses for Hearing Aids.
- Hearing Aids ordered prior to the effective date of Coverage under this Rider, even if delivered after Coverage begins.
- Hearing Aids ordered prior to the termination of Coverage under this Rider, but delivered after the Coverage ends.
- Charges for Audiometric Examinations, Hearing Aid Evaluation Tests, Conformity Tests and Hearing Aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the Provider.
- Benefits are not provided under this Rider for medical or surgical evaluation or treatment. NOTE: See your Member Certificate for medical coverage.
- Drugs or medications related to hearing problems.
- Examinations, tests, or Hearing Aids provided by a government agency at no cost to Member.
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids.
- Charges for spare Hearing Aids.
• Hearing Aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.

• Non-prescription, non-conventional Hearing Aids and devices.

All the provisions in your Certificate and related Riders are unchanged except as stated in this Rider.
A. DEFINITIONS:

1. APPROVED AMOUNT is the lower of the billed charge or the sum of the drug cost plus the dispensing fee for a Covered Drug or service. The drug cost and the dispensing fee are set according to our contracts with pharmacies. The Approved Amount is not reduced by manufacturer discount programs or coupons, rebates or other credits received directly or indirectly from a drug manufacturer. Deductible, Copayment and Coinsurance that may be required of you are subtracted from the Approved Amount before we make our payment. When a Participating Pharmacy fills a prescription for a Covered Drug, we will pay the pharmacy the Approved Amount for the drug after your out-of-pocket costs.

2. BCN AFFILIATED PROVIDER means a licensed health care provider who may prescribe prescription drugs and who is: a) contracted or employed with BCN; b) a health care provider to whom a Member was referred by BCN or BCN Physician; or, c) a licensed doctor of dental surgery or doctor of dental medicine in good standing with Blue Care Network.

3. BIOLOGICAL PRODUCTS mean Prescription Drugs including biosimilars and interchangeable biologics that are used to treat or cure disease and are manufactured in, extracted from or semi-synthesized from biological sources. Biological sources include microorganisms or plants or animal cells.

4. BRAND NAME DRUG generally means a drug that is manufactured and marketed under a registered trade name or trademark.
   - MULTI-SOURCE BRAND NAME DRUG means a drug that is available from a brand name manufacturer and also has generic versions available.
   - SINGLE SOURCE BRAND NAME DRUG means no generic is available because the drug can only be produced by the company holding the patent.
5. **COINSURANCE** means a percentage of the BCN Approved Amount you must pay for a covered service. Your Coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

6. **COPAYMENT** means a fixed amount of the drug’s BCN Approved Amount you must pay for a covered service.

7. **COVERED DRUG** means a Generic Drug, Single Source Brand Name Drug or a Biological Product which is included on the Custom Select Drug List, that is prescribed by a Provider and is **not excluded under Section E of this Rider**. This definition may be expanded at the discretion of BCN to include other drugs or devices that meet all of the requirements of this section.

8. **CUSTOM SELECT DRUG LIST** means the list of Prescription Drugs that have been approved by the U.S. Food and Drug Administration (“FDA”) and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee and are covered under this Rider. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Select Drug List require Prior Authorization and/or Step Therapy by BCN before they are covered. The Custom Select Drug List may be modified by BCN as needed to remove or add a Covered Drug or to modify the requirements for authorization of a Covered Drug.

9. **EXCLUSIVE PHARMACY NETWORK FOR SPECIALTY DRUGS** is a pharmacy network selected by BCN to provide covered Specialty Drugs to our Members. The pharmacy network agrees to accept BCN’s Approved Amount as payment in full for covered Specialty Drugs.

10. **EXIGENT CIRCUMSTANCES** is when you suffer from a health condition that may seriously jeopardize your life, health or your ability to regain maximum function or when you are undergoing a current course of treatment using a drug that is not on the Custom Select Drug List.

11. **GENERIC DRUG** means a Prescription Drug that contains the same active ingredients, is identical in strength and dosage form and is administered in the same way as the brand name drug. Generic Drugs are generally included in Tier 1A and Tier 1B and usually cost significantly less than the Brand Name drug equivalent.

12. **MEDICALLY NECESSARY** or **MEDICAL NECESSITY** means 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 patient’s condition and not mainly for the convenience of the Member or physician. In the absence of
established criteria, Medical Necessity will be determined by pharmacists and physicians according to accepted standards and practices.

13. NON-PARTICIPATING PHARMACY means a pharmacy that does not have an agreement with BCN to provide Covered Drugs. Non-Participating Pharmacies have not agreed to accept the Approved Amount as payment in full for Covered Prescription Drugs. You may be responsible for any amount that the Non-Participating Pharmacy charges that is above the BCN Approved Amount. This additional cost will not apply toward your Out-of-Pocket Maximum.

14. OFF-LABEL means the use of a drug or device for clinical indications other than those stated in the labeling approved by the FDA.

15. OUT-OF-POCKET MAXIMUM is the highest amount of money you have to pay for covered services during the benefit year. Member Cost-Sharing for medical Benefits, hearing and Prescription Drugs covered under this Rider count toward your Out-of-Pocket Maximum. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to your Out-of-Pocket Maximum. This limit never includes Prescription Drugs not covered by BCN. The In-network and Out-of-network Out-of-Pocket Maximums are defined in your Certificate of Coverage.

16. “OVER THE COUNTER” DRUGS means a drug that can be sold without a prescription.

17. PARTICIPATING PHARMACY means a network of licensed pharmacies selected by or authorized by BCN to provide Covered Prescription Drugs to members.

18. PERSONALIZED CARE PROTOCOL PROGRAM means a program that supports Members needing enhanced coordination of care for controlled substances. Members enrolled in this program are identified by BCN. BCN will send the Member a letter 30-days before the program takes effect that explains the program’s requirements and its effective date.

19. PRESCRIPTION DRUG means a medication approved by the FDA and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a Federal legend drug).

20. PREVENTIVE MEDICATIONS are Preventive Prescription Drugs that are maintained by BCBSM/BCN based on A and B recommendations by the U.S. Preventive Services Task Force (USPSTF) and mandated under the Patient Protection and Affordable Care Act. Some BCN Preventive Medications require Preauthorization and/or Step Therapy by BCN before they are covered. The Preventive Medications may be modified as needed based on USPSTF guideline or to modify the requirements for authorization of a Covered Drug.
21. PRIOR AUTHORIZATION means obtaining BCN’s advanced approval for certain Prescription Drugs before the requested drug is covered. Approval is based on whether the information that your physician provides regarding your medical condition meets BCN’s clinical criteria.

22. SPECIALTY DRUGS mean Prescription Drugs that require special handling, administration or monitoring. These drugs treat complex and chronic conditions such as cancer or chronic kidney failure. BCN determines which specific drugs are considered specialty and payable through the pharmacy benefit. A list of covered Specialty Drugs is available at www.bcbsm.com.

23. STEP THERAPY PROGRAM means a program where a Member must be treated with one or more generic or preferred drugs before certain drugs are covered.

24. TIER 1A PREFERRED GENERICS generally are select Generic Drugs that have a proven clinical value essential for treatment of chronic conditions such as diabetes and hypertension. These drugs have lower Cost Sharing compared to Tier 1B Generics.

25. TIER 1B GENERICS are those drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. These drugs generally have lower Cost Sharing compared to Tier 2 Preferred Brand.

26. TIER 2 PREFERRED BRAND Drugs are those Single Source Brand drugs that have a proven record for safety and effectiveness. These drugs generally are more expensive than generic drugs. Generic Drug alternatives may be available, offering more cost-effective therapies.

27. TIER 3 NON-PREFERRED BRAND Drugs are Covered Drugs that may have less favorable adverse effects, or their clinical value may not be as high as the BCN preferred alternatives. The higher Cost Sharing applies.

28. TIER 4 PREFERRED SPECIALTY Drugs are those generic or Single Source Brand Specialty Drugs that have a proven record for safety and effectiveness, and offer the best value to our Members. The lowest Specialty Drug Cost Sharing applies.

29. TIER 5 NON-PREFERRED SPECIALTY DRUG are those covered Specialty Drugs that may have less favorable adverse effects, or their clinical value may not be as high as the Specialty Drugs on Tier 4 Preferred Specialty. The highest Specialty Drug Cost Sharing applies.
B. BENEFITS:
- Covered Drugs
- Injectable insulin when prescribed by a Provider
- Specialty Drugs when obtained from a pharmacy in BCN Exclusive Pharmacy Network for Specialty Drugs
- Disposable insulin syringes and needles
- **A and B rated preventive medications as recommended by the U.S. Preventive Services Task Force (USPSTF) and defined as preventive on the Custom Select Drug List.

C. COPAYMENT/COINSURANCE:

Retail Prescription Drug Copayment/Coinsurance, up to a 30-day maximum supply per prescription:

Note: The In-Network and Out-of-Network Out-of-Pocket Maximum amounts are defined in your Certificate of Coverage. Once you reach the defined Out-of-Pocket Maximum amounts, your Covered Drugs are covered in full.

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1A Preferred Generics</td>
<td>$6 Copayment</td>
</tr>
<tr>
<td>Tier 1B Generics</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand</td>
<td>$80 Copayment</td>
</tr>
<tr>
<td>Tier 4 Preferred Specialty</td>
<td>20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200)</td>
</tr>
<tr>
<td>Tier 5 Non-Preferred Specialty</td>
<td>20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300)</td>
</tr>
<tr>
<td>*A and B Preventive Medications – must Covered in full for Generic and Single Source</td>
<td></td>
</tr>
<tr>
<td>Drugs for Treatment of Sexual Dysfunction</td>
<td></td>
</tr>
<tr>
<td>Cough &amp; Cold Remedies</td>
<td></td>
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<tr>
<td>Prenatal Vitamins</td>
<td></td>
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<tr>
<td>Compounds</td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td></td>
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<tr>
<td>Select High Abuse Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred and non-Preferred Specialty Drugs</td>
<td></td>
</tr>
<tr>
<td>obtained from a pharmacy not in our Exclusive Pharmacy Network for Specialty Drugs</td>
<td></td>
</tr>
<tr>
<td>Disposable Insulin Syringes and Needles</td>
<td>Applicable Tiered Copay</td>
</tr>
<tr>
<td>**A and B Preventive Medications – must</td>
<td>Covered in full for Generic and Single Source</td>
</tr>
</tbody>
</table>
be dispensed through a Participating Pharmacy with a prescription | Brand names on the Custom Select Drug List. Multi-Source Brands are not covered.

Prescriptions filled at an Out-of-Network Pharmacy

- The above Cost Sharing will apply
- You are responsible for any cost above the BCN Approved Amount. This cost will not apply to your Out-of-Network Out-of-Pocket Maximum.
- You will need to seek reimbursement for prescriptions filled at an out-of-network pharmacy
- Prior Authorization and Step Therapy rules will continue to apply

<table>
<thead>
<tr>
<th>Female Contraceptives when defined as preventive under the Custom Select Drug List</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1A Preferred Generics</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Tier 1B Generics</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand *</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand *</td>
<td>$80 Copayment</td>
</tr>
<tr>
<td>Tier 4 Preferred Specialty</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Tier 5 Non-Preferred Specialty</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*Your Tier 1B, Tier 2 and Tier 3 cost sharing may be waived for female contraceptive drugs if there are no appropriate generic products or preferred drugs available. A Provider must first certify to BCN and BCN must agree that the available generic and preferred drugs are ineffective or pose unnecessary risk to you. In such instances, the cost sharing is waived only if the covered female contraceptive drug is dispensed by the Pharmacy and the request for coverage is approved by BCN.

D. LIMITATIONS:

1. Prescriptions for Covered Drugs are limited to a 30-day retail supply except that BCN in its discretion may recognize for benefit purposes the provision of specific prescription drugs in quantities exceeding a 30-day supply. BCN retains the right to place a lower maximum supply limit on certain Covered Drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers). This Rider does not cover any prescription refill in excess of the number specified by the physician or any prescription or
refill dispensed after the date the prescription has expired. In addition, BCN may set quantity limits based on clinical appropriateness and manufacturer recommended dosing for particular drugs.

**Note:** BCN reserves the right to limit the quantity of select Specialty Drugs to a 15-day supply. Your Copayment maximum will be reduced by fifty percent (50%) for the 15-day supply.

2. BCN will reimburse a Member the amount specified on BCN’s fee schedule or Member’s out-of-pocket cost, whichever is less, minus the Copayment or Coinsurance, if a Member obtains Covered Drugs, needles and syringes, or insulin from a non-participating pharmacy in an urgent situation or when a Member is out-of-area and a Participating Pharmacy is not available.

3. A and B rated preventive medications and devices are covered under this Rider with a valid prescription from a Provider. Prior Authorization, Step Therapy and quantity limits may apply.

4. Included in the Custom Select Drug List are Covered Drugs which are benefits under this Rider only if a 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 by BCN without Prior Authorization by BCN.

5. Some drugs require Step Therapy before the prescribed drug is covered. These drugs require a previous trial with one or more preferred drugs before coverage is provided.

6. Certain drugs are not covered unless your Provider first certifies to BCN and BCN agrees that the available generic and preferred drug alternatives on the Custom Select Drug List are ineffective or pose unnecessary risk to you. In such instances, the request for coverage must be approved by BCN as medically necessary, based on BCN’s approved criteria. The highest Tier Cost Sharing (Tier 3 or Tier 5 depending on specialty designation) will apply.

7. For a Member enrolled in the Personalized Care Protocol Program, the controlled substance is only covered when prescribed by the assigned Provider and dispensed by a BCN approved Pharmacy. If a Member cannot meet these requirements, such as when they are traveling, the controlled substance will be covered only if BCN approves the prescribing provider and the pharmacy before a controlled substance is dispensed.

**Note:** Only controlled substances fall under this program. For all other Covered Drugs, members can go to a Provider or Pharmacy of their choice.
E. EXCLUSIONS:

There is no coverage under this Rider for:

1. Multi-Source Brand Drugs

2. 90-day retail supply fills or mail order

3. Covered Drugs, needles and syringes, or insulin provided by any private or public agency, which are or may be obtained by the Member without cost to the Member

4. Any drug which is experimental or which is being used for experimental purposes including, but not limited to, those regarded by the FDA as investigational.

5. Any prescription which is filled after termination of this Rider or which is filled prior to termination of this Rider but provides more than a 30-day supply of a Covered Drug beyond the termination date.

6. Any cosmetic drug or drug used for cosmetic purposes. “Cosmetic drug” or ‘cosmetic purpose” means any prescription legend drug which is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting hair growth, reducing or eliminating wrinkles or altering the appearance, and any substance intended to be used as a component of the above drugs.

7. Prescription drugs ordered for or dispensed to a Member when the drug is part of and included in a benefit under the Member's Certificate. Coverage for such drugs, including vaccines, serums, and drugs for treatment of infertility, are subject to the benefits, limitations, exclusions and Cost Sharing requirements of the Member's Certificate.

8. Specialty Drugs obtained from any pharmacy not in our Exclusive Pharmacy Network for Specialty Drugs. BCN has contracted with our Exclusive Pharmacy Network for Specialty Drugs to provide your Specialty Drugs. Contact Customer Service for the location nearest you. If you obtain your Specialty Drugs from any other pharmacy, you may be responsible for the total cost.

9. Any Prescription Drug, insulin, or needles and syringes to the extent that benefits or coverage are available under Medicare or under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

10. Any drug, needles or insulin that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or
prescribed for the Member in accordance with generally accepted professional procedures.

11. Over-the-Counter drugs unless coverage is required under the Patient Protection and Affordable Care Act.

12. Prescription Drugs for which there is an Over-the-Counter equivalent in both strength and dosage form.

13. Replacement prescriptions resulting from loss, theft, or mishandling

14. Prescription Drugs that are compounded drugs

15. “Rx only” labeled therapeutic devices or appliances, regardless of the reason they were prescribed

16. Drugs that are not approved by the Federal Food and Drug Administration except for insulin or such drugs that BCN designates as covered.

17. Any drug or device prescribed for use or dosage other than those specifically approved by the FDA. This is often referred to as the Off-Label use of a drug or device. However, BCN will pay for such drugs and the reasonable cost of supplies needed to administer them as defined in the BCN off-label drug use policy, if the prescribing provider can substantiate that the drug is recognized for treatment of a condition for which it was prescribed.

18. Any drugs not reviewed and recommended by BCN for addition to the Custom Select Drug List

19. Prescription Drug prescriptions written by a provider who is sanctioned at the time the prescription is dispensed. The provider can be sanctioned by the Office of the Inspector General, State of Michigan or BCN.

20. The use, medical or otherwise, of marijuana (cannabis)

21. Drugs not yet approved by the BCBSM/BCN Pharmacy and Therapeutics Committee.

22. Hormonal therapy drugs for the treatment of idiopathic short stature, regardless of height percentile and growth speed
G. GENERAL PROVISIONS:

1. You, your designee, or the provider may request an exception if your Prescription Drug is not on the Custom Select Drug List. BCN must Prior Authorize the Prescription Drug before it is dispensed. If Prior Authorization is not given before it’s dispensed, the drug will not be covered.

To request an exception, you must follow BCN’s exception request process. The process is as follows:

- You, your designee, or the provider who prescribes a drug must contact BCN and request an exception for the drug that is not on the Custom Select Drug List.
- We will decide whether to grant the request once we receive all of the information we need to make a decision. We will notify you or your designee, the prescribing provider or the provider’s designee whether the request has been granted within 24 hours after receiving all of the needed information.

If you need more information about this process or if you wish to appeal a decision made under this process, go to www.bcbsm.com or call the Customer Service number on the back of your card.

If your request is based on Exigent Circumstances, the prescribing provider or other prescriber must submit an oral or written statement that:

- An exigency exists,
- The reason for the exigency,
- Why the Member must have the requested drug, including statement that all other drugs on the Custom Select Drug List:
  - will be or have been ineffective,
  - would not be as effective as the requested drug, or
  - would have an adverse effect on the Member

For the request to be approved, the drugs must:

- Be FDA-approved
- Meet BCN’s clinical criteria for the treatment of the Member’s condition

If Prior Authorization is not given before the drug is dispensed, the drug will not be covered. You will be responsible for 100% of the pharmacy’s charge. If the exception request is Prior Authorized, the applicable Non-Preferred Cost Sharing tier will apply.

To learn more about this process or if you wish to appeal a decision that involves an exigent circumstance, visit www.bcbsm.com or call the Customer Service number on the back of your ID card.
2. Until further notice, all terms, limitations, exclusions and conditions of the Member Certificate remain unchanged except as provided in this Rider.
BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

UNIVERSITY OF MICHIGAN

$3,500/$7,000 IN-NETWORK OUT-OF-POCKET MAXIMUM/
$3,500/$7,000 OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM

RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group.

Your annual In-Network and Out-of-Network Out-of-Pocket Maximum defined in your Certificate of Coverage is below. BCN covered Prescription Drugs, hearing and medical services apply to the Out-of-Pocket Maximum. Once you reach the defined integrated Out-of-Pocket Maximum amounts, your Prescription drugs are covered in full.

**In-Network Out-of-Pocket Maximum amounts**

- $3,500 per individual
- $7,000 per family (when two or more members are covered under one contract)

**Out-of-Network Out-of-Pocket Maximum amounts**

- $3,500 per individual
- $7,000 per family (when two or more members are covered under one contract)

**Exceptions**

Pharmacy drugs and services not covered by BCN and costs payable by you over the BCN Approved Amount do not apply to the In-Network or Out-of-Network Out-of-Pocket Maximum.

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

Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.
BLUE CARE NETWORK  
An affiliate of  
Blue Cross and Blue Shield of Michigan

BLUECARD® PROGRAM ADDENDUM

If you receive Covered Services in another state, the claims will be processed through the BlueCard® Program. This Addendum explains how it works. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

Your Certificate is amended to include the following:

Out-of-Area Services

Overview

Blue Care Network (“BCN”) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you, the Member, access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

 Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement (“nonparticipating providers”) with the Host Blue. BCN remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

BCN covers only limited healthcare services received outside of our Service Area. As used in this section “Out-of-Area Covered Healthcare Services” include, emergency care, urgent care, and/or follow-up care obtained outside the geographic area we serve, subject to BCN coverage rules. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless Preauthorized by your Primary Care Physician (“PCP”) or BCN.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and
those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCN to provide the specific service or services.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when you access Out-of-Area Covered Healthcare Services outside the BCN Service Area, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program will be based on the lower of the providers billed charges for Out-of-Area Covered Healthcare Services or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue’s healthcare provider contracts. The negotiated price made available to BCN by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Out-of-Area Covered Healthcare Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the
Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

B. Nonparticipating Providers Outside of the BCN Service Area

1. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of the BCN Service Area by nonparticipating providers, the amount(s) you pay for such services will generally be based on either the Host Blue’s nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCN will make for Out-of-Area Covered Healthcare Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

2. Exceptions

In some exception cases, BCN may pay claims from nonparticipating providers for Out-of Area Covered Healthcare Services based on the provider’s billed charge. This may occur in situations where you did not have reasonable access to a participating provider, as determined by BCN in our sole and absolute discretion or by applicable state law. In other exception cases, BCN may pay such a claim based on the payment BCN would make if BCN were paying a nonparticipating provider for the same Covered Healthcare Services inside of BCN Service Area, as described elsewhere in this contract. This may occur where the Host Blue’s corresponding payment would be more than BCN in-Service Area nonparticipating provider payment. BCN may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCN will make for the covered services as set forth in this paragraph.

C. Blue Cross Blue Shield Global® Core

General Information

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: “BlueCard Service Area”), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Healthcare Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of BlueCard Service Area...
Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these 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. In such cases, the Blue Cross Blue Shield Global® Core contracting hospital will submit your claims to the service center to initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for Covered Services. You must contact us to obtain Preauthorization for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard 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 Healthcare Services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for Covered Services outside the BlueCard 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 BCN, the service center or online at 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.

**D. Exclusions and Limitations**

This addendum will not apply if:

- the services are not a benefit under your Certificate of Coverage;
- the services are performed by a vendor or provider who has a contract with BCN for those services.

**E. General Information**

- If you have a Deductible, you will be responsible for payment of applicable Deductible for covered services at the time those services are received.
- Your Deductible, Coinsurance and Copayment requirements are based on your Certificate and Riders and remain the same regardless of which Host Blue processes your claim for services.
• Until further notice, all the terms, definitions, limitations, exclusions and conditions of your Certificate and related Riders remain unchanged.
Tell us what you think. Your opinions matter to BCN and help us improve how we serve our members. Please take a moment to share your thoughts about your enrollment experience. You can also take our online survey at bcbsm.com/bcnfeedback.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before enrolling, I received accurate information about BCN benefits.</td>
<td></td>
<td></td>
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<tr>
<td>The member handbook helps me understand my benefits.</td>
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<tr>
<td>I am satisfied with the BCN enrollment process.</td>
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</tr>
<tr>
<td>My early impression of BCN is favorable.</td>
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</tr>
</tbody>
</table>

Name: ____________________________
Address: ____________________________
City, State ZIP code: ____________________________

How could we have better met your needs during the enrollment experience?

________________________________________

Thank you for your feedback.

U-M Student
RU27332

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Southfield, MI 48086-5043

Customer Service
1-800-662-6667
711 (TTY users)
8 a.m. to 5:30 p.m.
Monday through Friday

bcbsm.com