Section 1: Blue Care Network Health Care System

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Pediatric Choice program
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Michigan Statute regarding HMOs

Blue Care Network is a certified health maintenance organization, pursuant to the Michigan Insurance Code and regulated by the state Department of Insurance and Financial Services.

You may obtain copies of the statute on the Web at Michigan.gov/dfis.

Department of Insurance and Financial Services
611 W. Ottawa, Third Floor
Lansing, MI 48933-1070
Tel: 1-877-999-6442

What we do

Blue Care Network contracts with physicians, hospitals and other providers to deliver care and provide service to members.

In addition to providing basic health care financing and customer services, we help promote the delivery of quality care in a cost-effective manner by supporting the efforts of our affiliated providers with a variety of wellness and chronic care programs.

Approach to care management

Blue Care Network’s health care system is based on primary care physicians who provide and manage medical care for our members.

BCN performs administrative and support functions that help maintain the quality of care provided to members, while controlling the cost of services. These functions include provider contracting, quality management, peer review, claims processing and payment, chronic care management, member inquiry and utilization management.

The flow chart on the next page shows how the BCN managed care system works...
Blue Care Network’s health care system (continued)

- Member selects a primary care physician
- Member treated by primary care physician for preventive and routine care
- If necessary, primary care physician refers member to other providers for these types of care
  - Specialty services (for example: allergy testing, dermatology, orthopedics)
  - Ancillary services (for example: durable medical equipment)
  - Hospital services
Blue Care Network’s health care system (continued)

Partners in care

Some BCN services are provided through subcontracted arrangements with vendors. The following table describes the BCN services provided by statewide vendors.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contracted Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient durable medical equipment, prosthetics and orthotics</td>
<td><strong>Northwood Inc.</strong> provides the statewide network for most DME/P&amp;O covered services and is contracted by BCN to serve as a third-party administrator and authorize and pay for all DME/P&amp;O covered services.</td>
</tr>
<tr>
<td>Outpatient diabetic materials</td>
<td><strong>J&amp;B Medical Supply Company</strong> partners with BCN to provide diabetic materials, including insulin pumps, blood glucose meters, test strips and lancets.</td>
</tr>
<tr>
<td>Outpatient laboratory services</td>
<td><strong>Joint Venture Hospital Laboratories</strong> provides the statewide network for BCN covered outpatient laboratory services and serves as a third-party administrator.</td>
</tr>
</tbody>
</table>
| Pharmacy (for services provided under the member’s pharmacy benefit) | **Express Scripts®**  
  • Processes prescription claims  
  • Provides mail service pharmacy program  
  • Manages the BCN Clinical Pharmacy Help Desk after hours and on weekends and holidays  
  • Provides coverage reviews for prior authorization after normal business hours  
  **Walgreens Specialty Pharmacy, LLC**  
  • Provides specialty pharmacy services |
Primary care physicians

A primary care physician is a medical doctor or a doctor of osteopathic medicine licensed in the state of Michigan whose practice is primarily:

- **Family medicine or general practice**: Practitioners who treat patients of all ages from newborns to adults
- **Pediatrics**: Pediatricians who treat infants, children and adolescents 18 years and younger.
- **Internal medicine**: Internists trained to identify and treat adult and geriatric medical conditions
- **Internal medicine/pediatrics**: Physicians trained in internal medicine and pediatrics who treat infants, children, adolescents and adults

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How the PCP works with members

The primary care physician provides and coordinates medical care and services for members. To access their benefits, members must select a participating primary care physician as soon as they join BCN. Our website (bcbsm.com/find-a-doctor) lists primary care physicians and specialists across the state.

Every primary care physician in our network meets BCN affiliation and credentialing requirements.

*continued*
Primary care physicians (continued)

PCP provides care

BCN’s primary care physicians provide the following types of care to members:
- Office visits for sick and well care
- Health exams
- Preventive care and related services
- Health education
- Inpatient consultation
- Follow-up on emergency room treatment

PCP coordinates care

The primary care physician is also responsible for issuing referrals for, and coordinating the delivery of, care that cannot be provided in the primary care office. Primary care physicians coordinate the following types of member care:
- Hospitalization
- Post-hospital care
- Specialty treatment
- Ancillary and specialty services, using BCN-contracted vendors
- Referrals to disease and case management
- Prescription medications, following BCBSM/BCN drug lists
- Referrals to health education programs

Note: BCN members with Blue Elect Plus Self-Referral Option are able to self-refer for services, but they pay more out of pocket when their primary care physician doesn’t provide or coordinate care.

PCP DOES NOT coordinate care for these

The primary care physician doesn’t need to coordinate:
- Woman’s Choice (see Page 1-14)
- Pediatric Choice (see Page 1-14)
- Behavioral health services
  (Members call 1-800-482-5982 to arrange this care.)

continued
**Primary care physicians (continued)**

**Members must choose a PCP**  
All members must choose a BCN participating primary care physician.  
**Note:** A family can choose one primary care physician for the whole family (must be family, general practice or internist/pediatrician), or each family member can select a different primary care physician.

**Finding a PCP**  
Members can find a doctor online using the provider search tool at [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor). The search tool provides such information as where the doctor trained, the doctor’s hospital affiliations and if the office accommodates languages other than English.

**Changing primary care physicians**  
We encourage members to build a long-term relationship with their primary care physicians. However, a member has the right to change his or her primary care physician at any time.  
Members can change physicians by:  
- Using the PCP search feature on our Web site:  
  [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor)  
- Calling Customer Service using the main number, 1-800-662-6667, or the number on the back of their ID card.  
- Mailing a completed Physician Selection form (sample follows) to:  
  Blue Care Network — H300  
  P.O. Box 5043  
  Southfield, MI 48086-5043

**Effective date of change**  
Primary care physician changes made by phone or online take effect immediately.  
Changes mailed to us become effective two business days from the time BCN receives the Enrollment/Change of Status/Primary Care Physician Selection form.

*continued*
Primary care physicians (continued)

Blue Cross Personal Choice PPO/BCN Primary Care Physician Selection (see Page 5 for instructions)

If you are enrolling in Blue Cross Blue Shield of Michigan Personal Choice PPO or Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections on this form.

You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician.

Need information about available primary care physicians?

Our website, bcbshm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care physicians. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

<table>
<thead>
<tr>
<th>Member Information</th>
<th>Member's last name, first name</th>
<th>Physician's last name, first name</th>
<th>Physician's NPI</th>
<th>Physician address</th>
<th>If changing PCPs, last reason</th>
<th>Seen in the last 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Spouse</td>
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<td></td>
<td>Yes</td>
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<tr>
<td>Dep. 1</td>
<td></td>
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<td>Yes</td>
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<td>Dep. 2</td>
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<td>Yes</td>
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<td>Dep. 3</td>
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<td></td>
<td>Yes</td>
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<tr>
<td>Dep. 4</td>
<td></td>
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<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

I have read and understand the conditions of this form. Signature: ____________________________

Return this form to start your health care partnership. We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

For Blue Cross Blue Shield of Michigan: Fax your complete form to 1-866-900-2519 or 1-866-900-2529
Or mail to:
Blue Cross Blue Shield of Michigan Membership and Billing - M.C. 6103
P.O. Box 2260
Detroit, MI 48226

For Blue Care Network:
Fax your complete form to 1-877-218-1466
Or mail to:
Blue Care Network
Membership and Billing - M.C. H300
P.O. Box 5043
Southfield, MI 48065-5043

All changes become effective two business days after we receive this form — unless you request a later effective date.

You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs. You may request to change your primary care physician effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.
Primary care physicians (continued)

Instructions for completing the Blue Cross Personal Choice/BCN Primary Care Physician Selection form on Page 4

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen, Enter a taxpayer identification number in the Social Security number field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx xx xxxx).
- Enter each member’s last and first name, physician’s last name and first name, physician’s NPI number, physician’s address and the reason for changing your primary care physician, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician’s NPI number when searching for a doctor on bcbsm.com/find-a-doctor.
- Enter the employer’s name and the date you changed to this physician.
- In the signature section, sign your full name and enter the date that you signed the form.

Note: Submit the Blue Cross Personal Choice/BCN Primary Care Physician form with your New Subscriber Enrollment form when enrolling with Blue Cross or BCN.
Provider responsibilities

PCP

It’s the responsibility of the primary care physician to:

- Provide telephone access, 24 hours a day, seven days a week. A triage mechanism should direct members to an appropriately trained health professional for emergencies.
- Accept a minimum number of BCN members and give 60 days written notice of a change in acceptance status.
- Provide for member care at all times and ensure that covering or “on call” medical personnel are of a like or similar specialty and are BCN-contracted providers who understand the procedures for managing BCN members.
- Provide primary care services to members within the scope of the physician’s medical specialty and coordinate ancillary or specialty services, in or out of the hospital, as medically indicated.

Specialist

It’s the responsibility of the specialist to:

- Accept referrals of BCN members from primary care physicians and provide services in a manner commensurate with the standards of practice for the physician’s specialty.
- Consult with and seek further authorization from the member’s primary care physician if treatment will exceed the dates of the initial referral.
- Provide a timely written report to the member’s primary care physician for inclusion in the member’s medical record.
- Use BCN-contracted agencies and facilities for tests or services provided to members, except as authorized by BCN.
- Allow primary care physicians, authorized BCN representatives, peer reviewers and government personnel access to the BCN member’s medical record upon request.
- Provide for member care at all times and ensure that covering or “on call” medical personnel are of a like or similar specialty and are BCN-contracted providers who understand the procedures for managing BCN members.

continued
**Provider responsibilities (continued)**

<table>
<thead>
<tr>
<th>Hospital and ancillary providers</th>
<th>BCN expects hospital and ancillary providers to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Accept referrals of BCN members from primary care physicians and, except in emergencies, provide only those services that were authorized.</td>
</tr>
<tr>
<td></td>
<td>• Consult with and seek further authorization from the member’s primary care physician or BCN, if necessary, for the following situations:</td>
</tr>
<tr>
<td></td>
<td>-- Additional treatment or tests needed</td>
</tr>
<tr>
<td></td>
<td>-- Treatment that will exceed the dates on the initial referral</td>
</tr>
<tr>
<td></td>
<td>• Use BCN-contracted providers and facilities for tests or services provided to members, except as authorized by BCN.</td>
</tr>
</tbody>
</table>
# Understanding the referral process

<table>
<thead>
<tr>
<th>About referrals</th>
<th>When members need specialty care, their primary care physicians refer them to participating providers.</th>
</tr>
</thead>
</table>
| Extensive network of specialists | BCN offers a statewide network of specialty care physicians. Most primary care physicians will generally refer to specialists who:  
- Are affiliated with their own physician group  
- Admit patients to the same hospital where the primary care physician is affiliated  
- The doctor knows and trusts |
| How referrals work | Here’s how the primary care physician issues referrals:  
- The member visits his or her primary care physician for an examination.  
- The physician determines the appropriate medical action.  
- If medically indicated, the primary care physician generates a referral to a BCN-contracted specialist. |
| Paper or electronic | A referral form may be given to the member or mailed to the specialist, depending upon the primary care physician’s referral process. The referral must also be filed with BCN. This can be done electronically through BCN’s e-referral process. |
# Global referrals

## Global referral care

A global referral is authorization from the primary care physician to a specialist to conduct office visits, tests or procedures for a BCN member during a specified period of time.

- The referral authorizes most services performed in the provider’s office that a specialist believes necessary to diagnose and treat a patient’s condition.
- The treatment period can range from 90 days to 365 days.
- Certain services require BCN authorization.
- Members who obtain specialty services without authorization will be responsible for the charges.
- The specialist cannot refer the member to another specialist without an additional referral from the primary care physician.
- A member who is receiving specialty care and changes primary care physicians must make an appointment to see the new primary care physician and obtain a new authorization. Referrals issued by the former primary care physician become invalid upon the effective date of the new primary care physician.

## Regional referral differences

Blue Care Network’s referral requirements vary based on where the member lives and the primary care group affiliation of the member’s primary care physician.

## East and Southeast service areas

For members whose primary care physician is in the East or Southeast service area, select services are payable from a global referral if they are performed in a physician’s office. Plan notification is required when the service is performed in a facility outpatient setting.

## Mid and West service areas

For members whose primary care physician is in the Mid or West service area, a paper referral is not required in most cases. However, all care must be coordinated by the primary care physician.
**Plan notification**

<table>
<thead>
<tr>
<th>Referral not needed</th>
<th>Some services don’t need referrals. These include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Routine OB-GYN services for female members that are provided by a contracted OB-GYN physician (See Woman’s Choice Pages 1-14 and 1-15)</td>
</tr>
<tr>
<td></td>
<td>• Mental health and substance abuse services (Members call 1-800-482-5982 to arrange this care.)</td>
</tr>
<tr>
<td></td>
<td>• Services covered under Pediatric Choice guidelines (see Page 1-14)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BCN authorization</th>
<th>Primary care physicians and specialists must submit certain services to BCN for review before delivery of the service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In addition all services to be performed in an outpatient facility setting (for example: surgical procedures) require BCN notification before the date of service.</td>
</tr>
<tr>
<td></td>
<td>When services require plan approval, BCN sends written authorization to the member and the referring physician.</td>
</tr>
</tbody>
</table>
Pediatric Choice program

Choosing a pediatrician as a PCP

The parent of a BCN member under 18 may select either a pediatrician or a family or general practitioner as the minor’s primary care physician. If a family or general practitioner is selected, the minor may also use a pediatrician for general pediatric services.

No referral is required to receive pediatric services from the pediatrician, even when the pediatrician is not the minor’s primary care physician.
## Woman’s Choice Program

<table>
<thead>
<tr>
<th>Certain women’s services don’t require referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women have a choice. The Woman’s Choice program allows all female BCN members to see affiliated obstetricians or gynecologists for many obstetric or gynecologic services without a referral. Members may also have their primary care physicians provide these services. The member does not need to contact BCN to request to be assigned to a Woman’s Choice physician. Members may select an OB-GYN or gynecologist in one of these ways:</td>
</tr>
<tr>
<td>• On the BCN website bcbsm.com/find-a-doctor</td>
</tr>
<tr>
<td>• By calling Customer Service, using the main number, 1-800-662-6667, or the number on the back of their ID card.</td>
</tr>
<tr>
<td>We recommend that members discuss their selection with their primary care physicians. We also recommend that the member select a Woman’s Choice physician who has the same hospital affiliation as her primary care physician. This will facilitate hospital services when needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services that require approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>For specifics about services that require authorization for the primary care physician or plan approval, see the Woman’s Choice Referral and Clinical Review Guidelines.</td>
</tr>
</tbody>
</table>
Emergency care and urgent care

Emergency care

If a member experiences an immediate and unforeseen medical emergency and the time needed to contact his or her BCN primary care physician could result in permanent damage to the member’s health, the member should seek treatment from the nearest emergency room or call 911.

BCN suggests, but does not require, that the member, the hospital, or someone acting on behalf of the member notify the member’s primary care physician or BCN within 24 hours of the emergency treatment or as soon as it is medically reasonable to do so. This will help ensure that the member’s primary care physician can arrange appropriate follow-up care.

Emergency and urgent care providers should send a written summary of the services provided and the treatment plan to the primary care physician within 30 days of the date of service.

If a member receives emergency care while traveling outside the United States and the care is not coordinated through BlueCard, he or she will need to submit:

- An itemized bill
- Proof of payment
- Any medical records for review

Urgent care

Urgent care is outpatient care provided when the medical condition is not an emergency but still requires prompt attention (such as high fever, unusual pain or a minor injury).

We encourage our members to contact their primary care physicians to assist in arranging urgent care services required after hours. It is not necessary to submit a referral to BCN for urgent or emergent services.
**BCN Service Area**

**BCN service areas** A Blue Care Network service area is a county where health care coverage is offered. BCN serves all Michigan counties, as shown in the map below.

For member convenience, we publish two directories, one for the Greater Michigan region and another for the Southeast region. Each lists the primary care physicians and specialists for the counties in that region.

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*continued*
**Service Area (continued)**

**Out-of-area members**

BCN will accept out-of-area members if they live or work within 30 minutes of a BCN-contracted primary care physician. An out-of-area member is someone who meets full-time requirements as specified in the Group Enrollment and Coverage Agreement and resides in a county where BCN is not offered but is adjacent to a BCN service area. This individual agrees to obtain all health care except for emergencies in the BCN service area.

**Out-of-area counties**

- Ohio counties bordering Michigan BCN service areas: Lucas
- Indiana counties bordering Michigan BCN service areas: Elkhart, LaGrange, Steuben, St. Joseph
- Windsor, Ontario, Canada
Care while traveling

**Carry the card** Members should always carry their BCN ID cards when traveling. See the sample card below.

![Sample BCN ID card]

**Emergency care** No matter where the member may be traveling, he or she is always covered for emergencies. Members should go to the nearest emergency room or call 911. Members should also notify their primary care physician within 24 hours of their emergency treatment so the doctor can coordinate their follow-up care.

**Urgent care** Urgent care is available throughout the state in any area where BCN is offered. To locate a participating urgent care center, members should call Customer Service, using the main number, 1-800-662-6667, or the number on the back of their ID card, or by visiting [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor).

BlueCard helps members who need urgent care locate a provider at their travel destination.

**Follow-up care** If members need follow-up care, they should contact their primary care physician before leaving home to coordinate services that don’t require immediate attention.

continued
Care while traveling (continued)

Travel outside Michigan

One of the many benefits of BCN is that coverage travels with the member.

Blue Care Network provides out-of-state care through BlueCard, a Blue Cross Blue Shield Association program that gives members access to physicians anywhere in the United States outside of Michigan where a Blue Plan is offered. The BlueCard® program is explained online at bcbsm.com/bluecarddisclosure.

Members call the BlueCard 24-hour telephone line 1-800-810-BLUE (2583). A BlueCard representative provides the names of Blues participating providers at the member’s travel destination.

Extended stays out of state

Sometimes members need to live away from home for a period of time. College students or families who spend substantial time at a vacation home fall into this category.

Members who plan to live out of state for a period of time should contact BlueCard at 1-800-810-BLUE (2583) for a Blues-participating provider in the area where they will be located. College students or families who spend substantial time at a vacation home fall into this category.

Getting medications out of state

BCN members can have their prescriptions filled at any of the 65,000 pharmacies in our network, including chain and independently owned stores. They can visit bcbsm.com/find-a-doctor for participating pharmacies in Michigan, or call Customer Service, using the main number, 1-800-662-6667, or the number on the back of their ID card, for a list of participating pharmacies out of state.
# Section 2: Chronic Condition Management and Health Education Programs

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Blue Cross® Health &amp; Wellness umbrella of care</td>
<td>2-1</td>
</tr>
<tr>
<td>Chronic condition management overview</td>
<td>2-2</td>
</tr>
<tr>
<td>Asthma program</td>
<td>2-3</td>
</tr>
<tr>
<td>Heart disease program</td>
<td>2-3</td>
</tr>
<tr>
<td>Kidney health program</td>
<td>2-3</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease program</td>
<td>2-4</td>
</tr>
<tr>
<td>Depression program</td>
<td>2-4</td>
</tr>
<tr>
<td>Diabetes program</td>
<td>2-5</td>
</tr>
<tr>
<td>Heart failure program</td>
<td>2-6</td>
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<tr>
<td>Health education programs</td>
<td>2-7</td>
</tr>
<tr>
<td>Personal care plan letters</td>
<td>2-7</td>
</tr>
<tr>
<td>Self-help Guides</td>
<td>2-7</td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td>2-8</td>
</tr>
<tr>
<td>Online resources</td>
<td>2-9</td>
</tr>
<tr>
<td>Online tools</td>
<td>2-9</td>
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<tr>
<td>Log in</td>
<td>2-9</td>
</tr>
<tr>
<td>Member discount program</td>
<td>2-10</td>
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<tr>
<td>Blue 365®</td>
<td>2-10</td>
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</tbody>
</table>
The Blue Cross Health & Wellness umbrella of care

Blue Cross Health & Wellness is an umbrella of programs designed to help members stay healthy, get better or improve their quality of life while living with a chronic illness. Our programs provide a wealth of information, tools and assistance to help chart the course toward a healthier lifestyle.

Contact information

Health Education 1-800-637-2972
To request health education materials, self-management tools, assistance with health choices and self-help health guides.

Chronic Condition Management 1-800-392-4247
To obtain additional information about BCN’s chronic condition management programs or to enroll members in programs:
Chronic condition management overview

Helping members live healthier with illness

BCN’s chronic condition management programs help members who have certain chronic illnesses better understand and manage their condition. The programs are offered at no charge, and participation is voluntary.

Members are identified for participation in chronic condition management programs through claims data, physician referral or member self referral. Physicians wishing to refer a member to the chronic condition management program can do so by calling 1-800-392-4247.

Benefits

The chronic condition management programs educate members, help physicians care for their patients better and improve productivity of employees by reducing time out for illness. They feature:

- Educational materials and self-management tools mailed to members at their homes
- Coordination of care for members with more complex conditions

The programs also help physicians by enabling them to track patient-specific services for members

continued
### Chronic condition management overview (continued)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Program Details</th>
</tr>
</thead>
</table>
| **Asthma management program** | The asthma management program emphasizes member education and self-management. Members ages two and older who have been diagnosed with asthma are eligible. Educational materials address:  
- Asthma self-management techniques and triggers  
- Recognition of early symptoms and how to follow a written asthma management plan.  
- The roles of quick-relief bronchodilator and long-term control anti-inflammatory medications |
| **Heart disease program** | The heart disease program is available to all BCN members 18 years and older who have been diagnosed with heart disease. Educational materials address risk factors and self-management tools. Through the program, members develop a plan to reduce their risks for disease progression. All members who experience an acute cardiac event are offered active case management by BCN case management nurses. |
| **Kidney health program** | The kidney health program is for members 18 years and older who have been diagnosed with chronic kidney disease at stage 3. Goals of the program include:  
- Improved member understanding of the disease process  
- Teaching members the importance of controlling other contributing chronic conditions such as diabetes  
- Helping members follow dietary restrictions  
- Member compliance with the prescribed treatment plan  
- Monitoring symptoms  
Program participants are assured of regular BCN communications with primary care doctors and specialists. |

*continued*
### Chronic condition management overview (continued)

<table>
<thead>
<tr>
<th>Chronic obstructive pulmonary disease program</th>
<th>The COPD program is for members age 18 years and older who have been diagnosed with COPD, emphysema or chronic bronchitis. The program emphasizes member education, improved provider practices and case management nurse initiatives including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Use of a written COPD action plan to guide member self-management</td>
</tr>
<tr>
<td></td>
<td>- Symptom recognition</td>
</tr>
<tr>
<td></td>
<td>- The role of advanced directives</td>
</tr>
<tr>
<td></td>
<td>- Verification of diagnosis by pulmonary function testing</td>
</tr>
</tbody>
</table>

| Depression program                          | The BCN depression program is available to all members 18 years and older who have been diagnosed with major depression by their primary care physician and who have received a new prescription for an antidepressant medication. Members receive educational material about depression and the importance of adhering to their prescribed medication regimen. They are also reminded about missed antidepressant medication refills |

continued
The diabetes management program helps members manage their diabetes and reduce long-term complications through education and continuous medical follow-up. Members ages 18 years and older with diabetes (type 1 or type 2) are eligible. Network hospital-based educational programs are available for BCN members who:

- Are newly diagnosed
- Have gestational diabetes
- Require an annual diabetes education or meal plan update

These services require a referral from the member’s primary care physician. The primary care physician or member schedules the appointment by calling the network hospital-based program.

BCN periodically sends educational materials to BCN members with diabetes covering the following:

- Meal planning
- Staying active
- Using medications
- The importance of regular screening for blood sugar, eye and foot problems
- Cardiovascular risks associated with diabetes
- How to handle the depression that often accompanies chronic conditions.

The program also reminds participants about needed services such as annual retinal exams, flu vaccine, monitoring nephropathy and checking hemoglobin A1c and cholesterol levels.
Heart failure program

The heart failure program works with members ages 18 years and older who have been diagnosed with congestive heart failure. BCN helps members:

- Understand the body’s physical changes as a result of congestive heart failure
- Understand how staying active can improve overall emotional and physical well-being
- Recognize and manage symptoms
- Learn how to restrict sodium in meal planning

BCN also provides the medications needed to control the disease and offers the AMC Health Remote Monitoring Program. This alert system helps identify disease symptoms early and facilitates timely treatment interventions to prevent unnecessary hospitalization or emergency room visits.
# Health education programs

## Health education overview

BCN’s Health Education department supports a variety of programs for men and women of all ages. The goal is to help members stay on top of their health by providing information about weight management and nutrition, stress management, exercise and fitness and other health issues.

Members call 1-800-637-2972, a 24-hour message line, and request health information or leave a question for a return call.

## Personal care plan letters

BCN tracks members eligible for certain health screenings or services and reminds them about the importance of the service. Members are alerted to these services through personal care plan letters that are mailed to the home and by telephone calls as needed. The preventive health recommendations included are:

- Screening tests for members with diabetes
- Breast cancer screenings
- Cervical cancer screenings
- Childhood immunizations
- Adolescent immunizations
- Flu vaccines
- Annual checkups, including blood pressure, cholesterol and colorectal testing

## Self-help guides

Members can order self-help guides from the Health Education department. Topics include:

- Children’s guide to healthy nutrition
- Eating and exercising for better health
- Feeding your baby from birth to age 2
- Healthy approaches to menopause
- High blood pressure
- Hope and help for depression
- Quitting smoking for life
- Stress management
- Taking control of your cholesterol
- Taking control of your weight

*continued*
Tobacco cessation

Blue Care Network provides a telephone-based program, Tobacco Cessation Coaching, at no extra cost to any Blue Care Network member. It includes five calls from a health coach over a 12-week period. During the coaching calls, a health coach helps the member work toward a goal of quitting tobacco.

Members also have access to many online tools through the Blue Cross Health & Wellness site to help them quit tobacco.

Members can call 1-855-326-5102 to schedule their first Tobacco Cessation Coaching call.
Online resources

Online tools  Members who open an account at bcbsm.com have access to the Blue Cross Health & Wellness website and can do the following:

- Take a health assessment
- Participate in Digital Health Assistant® programs
- Sync their favorite fitness and medical devices and apps with the website
- Track personal health information
- Watch informational videos
- Access quizzes, slide shows and other interactive tools
- Find healthy recipes
Member discount program

Blue365  Member discounts with Blue365® offers exclusive savings on products and services for a healthy lifestyle, including fitness and wellness, healthy eating, travel, personal care and more. Members access these deals by logging in to their member accounts at bcbsm.com and clicking Member Discounts with Blue365® on the right side of the home page.
Section 3: Pharmacy Services

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## Overview of Pharmacy Services

### What the department does

The primary responsibilities of Pharmacy Services are to:

- Manage BCN commercial pharmacy benefits and drug formularies in our pharmacy claims system
- Develop and implement innovative benefit designs and cost-saving programs
- Provide access to high-quality, cost-effective drug therapy for members
- Monitor clinical standards involving the use of pharmaceuticals
- Assist in drug therapy evaluation
- Monitor drug therapy for members
- Educate practitioners and members regarding drug therapy
- Vendor (ESI and Highmark) relationship management - drug rebates contracting and administration for commercial and Medicare BCN and Blue Cross members
- Oversee adherence with CMS, state and compliance regulations and certificate and rider requirements
- Support certifications and performance measures required for NCQA, HEDIS, CAHPS and national health care reform
- Provide communications, to members and providers in support of clinical initiatives, drug list documents and medication quality and safety reports

### Primary objective

BCN encourages the use of the lowest-priced treatment alternative among equally safe and effective alternatives.

We offer a variety of drug benefit options with a wide range of coverage levels and copayment amounts to meet the employer’s benefits strategy. Our drug plans are designed to ensure quality of care and appropriate drug selection.

### Drug therapy assistance

BCN employs full-time clinical pharmacists to assist physicians in prescribing medications for members.
**BCN’s Drug Lists**

**About our Drug Lists**

To help our members make the most of their prescription benefit dollars, Blue Cross Blue Shield of Michigan and Blue Care Network have compiled drug lists with the most cost-effective therapies.

The BCBSM/BCN Custom Drug List, the Custom Select Drug List and the Comprehensive Drug List are regularly updated lists of U. S. Food and Drug Administration-approved medications. They represent the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and the promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. The drug lists are organized by tiers, indicating the level of copayment required.

You can access the drug lists and related documents, which include the *Custom Quick Guide* and the *Custom Select Quick Guide* online at [bcbsm.com/BCNdruglists](bcbsm.com/BCNdruglists).

**Compliance with the BCN Drug List**

BCN pharmacy staff monitors the prescription patterns of practitioners and their use of approved medications.
## Prescription drug benefits

### Drug coverage options

Our members have different drug plans and, therefore, different prescription cost share amounts and benefits. Cost share responsibility can be a dollar amount (copayment or deductible) or a percentage (coinsurance) of the total prescription cost.

### Specialty drugs

Specialty drugs are prescription medications that require special handling, administration or monitoring and are used to treat complex chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis and rheumatoid arthritis.

Specialty drugs often require a higher copayment than nonspecialty medications. All members enrolled with a Custom Select Drug List and those enrolled in the BCN 3-Tier Plus Specialty drug rider or Custom Drug List 6-Tier drug rider have a higher cost share for specialty drugs.

Specialty drugs are limited to a 30-day supply. Some may also be limited to a 15-day supply, for which members pay half of their 30-day copayment.

### Drugs covered with no copay

Under the Affordable Care Act, some members can receive certain commonly prescribed drugs without any cost sharing. Examples are aspirin, folic acid, fluoride, iron, vitamin D, smoking cessation products, certain breast cancer prevention drugs and certain contraceptive medications. The member must meet plan requirements, and a valid prescription is required for coverage.

*continued*
### Prescription drug benefits (continued)

<table>
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<tr>
<th>Items covered as medical benefits</th>
<th>Some items are covered as medical rather than prescription drug benefits for most BCN members. They include:</th>
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<td></td>
<td>• Medical supplies (durable medical equipment)</td>
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<td>• Injectable drugs that require supervision by health care personnel or are administered in the doctor’s office</td>
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<tr>
<td></td>
<td>• Drugs requiring home infusion (certain antibiotics, pain medications)</td>
</tr>
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<td></td>
<td>• Vaccines</td>
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</tbody>
</table>

| Influenza and Pneumonia Vaccines | All BCN and BCN Advantage members, regardless of their drug coverage, can get influenza vaccines through a participating network retail pharmacy without any cost-sharing. Other vaccines such as pneumonia, shingles, HPV, Tdap and meningitis are available at no cost sharing for members who meet criteria. |

*continued*
### Prescription drug benefits (continued)

#### Exclusions

(Custom and Comprehensive Drug Lists)

The following items are not covered under most BCN prescription drug riders:
- Drugs used for experimental or investigational purposes
- Cosmetic drugs
- Drugs included as a medical benefit (such as injectable drugs and vaccines that are usually given in a doctor’s office)

Note: BCN members can get influenza, pneumonia, shingles, HPV, Tdap and meningococcal (except group B) vaccines at network retail pharmacies with a prescription.
- Replacement prescriptions resulting from loss, theft or mishandling
- Compounded drugs — with some exceptions
- Drugs not approved by the FDA

#### Additional Exclusions

(Custom Select Drug List)

The Custom Select Drug List has the same exclusions noted above for the Custom Drug List, with these additional exclusions:
- Brand-name drugs when there’s a generic version available
- Drugs used for erectile dysfunction
- Drugs used for weight loss
- Prenatal vitamins
- Drugs used to treat heartburn and acid reflux (except select generic versions)
- Drugs that treat cough and colds, including most antihistamines
- Over-the-counter medications (unless considered preventive by the U.S. Preventive Services Task Force)

*continued*
### Options for filling prescriptions

| Retail pharmacies | Our members may fill prescriptions at any participating BCN pharmacy.  
More than 2,400 retail pharmacies in Michigan and 65,000 retail pharmacies nationwide participate with BCN. |
|--------------------|--------------------------------------------------------------------------------------------------|
| 90-day supply from retail pharmacies | BCN members can obtain a 90-day supply of most maintenance medications from most retail pharmacies. A 30-day first fill is required before a 90-day supply of most brand-name medications are covered. The one-month trial helps ensure that the drug and dosage are correct for the member.  
For a list of pharmacies that participate in our 90-day program, please visit Pharmacy Services at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy). |
| Mail order prescriptions through Express Scripts® | Express Scripts offers mail order prescription services to BCN members with BCN prescription coverage.  
Mail order prescriptions for most maintenance medications can be written for up to a 90-day supply. The mail order copayment is determined by the member’s drug benefit. A minimum lead time of 10 to 14 days is required for mail order prescriptions. |
| Refills through Express Scripts | Members can reorder their mail order prescriptions online through BCN’s secured member portal or at [Express-Scripts.com](http://Express-Scripts.com).  
Members can call Express Scripts Customer Service at 1-800-229-0832 for refills. Express Scripts will not accept new prescriptions by phone. |

*continued*
Options for filling prescriptions (continued)

<table>
<thead>
<tr>
<th>Options</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Diabetic supplies and other devices</strong></td>
<td>BCN members can obtain diabetic supplies and devices required for medical management (such as insulin pumps, blood glucose meters, test strips and lancets) through our contracted supplier, J&amp;B Medical Supply Company. For more information, call J&amp;B Customer Service at 1-888-896-6233.</td>
</tr>
</tbody>
</table>
| **Specialty medications**    | Only Walgreens Specialty Pharmacy handles mail order prescriptions for specialty drugs, used to treat complex or rare conditions such as arthritis, asthma, multiple sclerosis, hepatitis C, and others.  
BCN members can fill prescriptions for injectable and other specialty drugs through either a participating BCN retail pharmacy or through Walgreen’s mail order program.  
Prescriptions for most specialty drugs are limited to a 30-day supply. Note: Some specialty drugs are limited to a 15-day fill.  
A list of medications included in the BCN Specialty Drug Program is available on our website at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy).  
For more information, call Walgreens Specialty Pharmacy Customer Service at 1-866-515-1355. |
Medications requiring prior authorization

Reviews required
We review the use of certain medications to ensure that members receive the most appropriate and cost-effective drug therapy. With step therapy, some drugs are covered only if one or more comparable and less expensive drugs have been tried first to treat the member's condition. Our prior authorization and quantity limits programs require that certain clinical criteria be met before coverage is provided. These conditions vary with the drug and the treatment. BCN pharmacy reviews requests for coverage for medications covered under both the pharmacy and medical benefit. Clinical criteria for these programs are based on current medical information and recommendations of the BCBSM/BCN Pharmacy and Therapeutics Committee.

Drug lists online show review required
You can view the list of drugs that require prior authorization or step therapy at bcbsm.com. Click on bcbsm.com/BCNdruglists.
Section 4: Your Group Coverage Agreement

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</table>
The Group Enrollment and Coverage Agreement is a contract between Blue Care Network and your group. It’s signed by your group’s decision-maker, your Blues sales representative or agent and the BCN underwriter. The agreement tells you what coverage your group has selected and who is eligible for coverage.

A sample Group Enrollment and Coverage Agreement follows, consisting of these four parts:

- New business checklist
- Part A (Group Letter of Agreement)
  Sets forth the contractual obligations of each party
- Part A — Exhibit 1
  Explains the link to the national BlueCard program covering services received away from home
- Part B
  Form to complete with the group’s demographics
  New hire/rehire options (codes)
- Part C
  Lists the small group products available
- New Group Attestation Form
  Used to determine group size and type
- Group Reimbursement Policy Acknowledgement
  Identifies plan reimbursement rules.

For additional copies of the agreement, contact your sales representative or independent agent.
New Business Check List
for Small Group

☐ Group Enrollment and Coverage Agreement (Parts A, B & C)
☐ Premium binder check payable to BCBSM or BCN
☐ Current UIA 1020 (Quarterly Wage Detail Report)
☐ Proof of Federal Identification (if not pre printed on QWDR)
☐ Enrollment forms (ECOS) for all enrolling employees. Forms must be complete. Please ensure that dates of hire, job title, and signatures are included. Medicare and COBRA fields must be completed if applicable.
☐ Copy of final Rate Quote with Quoting Census
☐ New Group Attestation Form - Medical Loss Ratio
☐ Waiver forms for full time employees not enrolling with date of hire, job title, and signatures.
☐ Leasing Agreement with payroll invoice (if applicable)
☐ Union Contract (if applicable)
☐ Multiple location survey (if applicable)
☐ Small Group Pediatric Dental Essential Health Benefit Acknowledgement (if applicable)

Requested Effective Date  /  /  
Signature of Group Executive on behalf of the Group and the Group Health Plan: ___________________________ Date: __________
Group Executive Email Address: ___________________________ 
Signature of Agent: ___________________________ Date: __________

Coverage will begin on the effective date, contingent upon approval from BCBSM/BCN Underwriting. BCBSM/BCN will send an acceptance letter to the group upon approval.
Blue Care Network of Michigan (BCN) will provide health care coverage to Member's, i.e., eligible persons enrolled through the group identified below (Group) and participating in Group's employee welfare-benefit plan providing health benefits (Group Health Plan or GHP) subject to the terms of applicable certificates and riders (Certificates and Riders), BCN's administrative and underwriting requirements, the Group Administrative Guide, (Guide), and the following terms and conditions of the Group Enrollment & Coverage Agreement:

1. Effective Date: Plan Year. This Agreement will become effective on the date established by BCN ("Effective Date") and only after applicable premiums are paid, and it will continue unless terminated as provided in Section 13. Coverage is renewable annually if Group continues to meet eligibility requirements.

The GHP's Plan Year, as that term is defined in the Patient Protection and Affordable Care Act, as amended, and applicable regulations (collectively, "PPACA"), is the one year period beginning on the Effective Date and ending one year (or less) later on the last day of the month immediately preceding the month in which the Effective Date falls ("Effective Date Month"). Each Plan Year thereafter shall begin on the first day of the Effective Date Month and end one year later.

Notwithstanding the foregoing, if Group identified a different Plan Year for the GHP when applying for coverage under this Agreement, which Plan Year must start the first day of a month ("Plan Year Start Date"), coverage shall begin on the Effective Date and shall continue until the end of the month immediately preceding the next Plan Year Start Date, which also shall be the first Renewal Date (as defined below). Thereafter, coverage under this Agreement shall commence on the Renewal Date and end one year thereafter. "Renewal Date" is the designated date upon which Group annually renews coverage and on which BCBSM's rate re-determination for the next annual coverage period becomes effective.

Group will notify BCN at least six months in advance of any change in the OHP Plan Year.

2. Group as Agent. For all purposes of this Agreement, including the payment of premiums, the Group is the agent for all Members (as defined below). Notice by or to the Group will satisfy any notice requirements of this Agreement and applicable Certificates and Riders.

3. Premiums. The Group must pay all premiums at least one-month in advance of the relevant monthly period. Group must pay all premiums related to any retroactive adjustments expressly permitted by BCN's underwriting rules. Refunds or retroactive credits of premium payments or retroactive additions or deletions of Members are not otherwise permitted under this Agreement. All premium rates are guaranteed for the applicable benefit period then in effect except for any government-mandated surcharges or subsidies and except if incorrect rates are identified. In the latter case, BCN will notify Group in writing that the rates will be corrected on the next available bill, 90 days following receipt of the notice of incorrect rates. At its discretion, BCN may terminate this Agreement immediately if premiums are more than thirty (30) days past due, with termination of coverage retroactive to the last date through which premiums were paid in full.

4. Eligibility. In order to be a Member, an enrolled individual must (A) meet the eligibility requirements set by Group and the requirements of BCN's underwriting rules, Certificates and Riders, and Part B of this Agreement, and (B) be either: (i) a proprietor, partner or shareholder actively managing Group's business, or (ii) a full time active employee of Group working at least thirty (30) hours per week or 17.2 to 30 hours per week, if that is the normal workweek for a full time employee and such policy is applied uniformly among all of Group's employees and without regard to health status-related factors. Deviation from 30 hours a week requires prior approval and must be noted in the exception area on Part B. A dependent of a Member shall also be deemed to be a Member if the dependent meets the requirement of (A) above.

Group warrants that all enrolled individuals meet the above requirements and that it will not enroll any ineligible individual. If an ineligible individual is enrolled, Group, agrees to indemnify and hold BCN harmless and reimburse BCN for all benefit payments made on behalf of such individual and any judgment, settlement, costs, expenses and reasonable attorney fees in connection therewith.

5. Enrollment Requirements. Group may offer the coverage described in Part C of this Agreement to eligible individuals as described in Section 4. To continue coverage, the number of eligible individuals enrolled in a Blue Care Benefit Program (Blue Care Network or Traditional, PPO, or any other program that BCN may establish) must at all times equal or exceed BCN enrollment, participation and underwriting requirements. The Group agrees to provide BCN or its designee with all information required to conduct an annual underwriting review and a payroll audit.

Continued on Page 3
6. Eligibility Information. Group shall provide timely and accurate eligibility information, including Medicare status, and identify all persons subject to the Medicare Secondary Payor statutes and regulations. Group acknowledges that BCN will rely upon the accuracy of all eligibility information Group provides, and Group shall indemnify and hold BCN harmless against any loss, claim or action, including costs, penalties and reasonable attorney fees, arising from the provision of inaccurate eligibility information.

7. Enrollment Applications. Member applications for coverage shall only be submitted according to BCN’s procedures that are set forth in the Guide. Rehires and persons renewing terminated memberships will be enrolled as new employees. All applicable premiums, including those for any retroactive periods, must be paid before such persons shall be deemed to be eligible for coverage.

8. Claims Dispute Procedures. A Member who disagrees with a claims determination must exhaust all steps of the applicable BCN internal grievance procedure provided in 2000 PA 250 [MCL § 550.1404] and 2000 PA 252 [MCL § 550.2213] before seeking other remedies. Any Member dissatisfied with the results of the BCN internal grievance procedure may be entitled to request an external review from the Department of Insurance and Financial Services as provided in 2000 PA 251, or may file suit in a competent court of jurisdiction as set forth in Section 15 of this agreement. If the Group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), a Member may also have a right to file a claim under § 502(a) of ERISA.

9. Open Enrollment. At least once a year, BCN will have reasonable access to eligible subscribers and members of the Group for purposes of open enrollment. Persons joining the Group between periodic open enrollment periods may enroll in BCN coverage at the time they meet eligibility requirements.

10. ERISA Fiduciaries. If the GHP is subject to ERISA, Group or its designee (other than BCN) shall be the Plan Administrator of the GHP under ERISA and shall have all of the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all eligible individuals of: (i) available benefits and any changes in benefits, (ii) termination of coverage for any reason, including the failure to make any payments when due, and (iii) COBRA rights, if any. Group delegates the responsibility and discretionary authority to process and pay claims to BCN as “claims administrator” and retains all other responsibilities and duties under ERISA not specifically delegated to BCN. BCN agrees to assume such responsibility and authority, including any responsibility it may have as a “named fiduciary” (as defined under ERISA §402) for purposes of its claims administration duties, to the extent that under the GHP and BCN it meets the definition of a “named fiduciary.” As the named claims administrator, BCN shall have the power and discretion to construe the terms of this Agreement and to determine all questions pertaining to the administration, interpretation, and application of this Agreement and any Certificates and Riders that involve eligibility for benefits and the payment or denial of claims. In addition, the parties agree that BCN shall have the responsibility for ensuring that its claims procedures comply with the Department of Labor’s Claims Procedures described in 29 C.F.R. Part 2500 and for handling all levels of appeal.

11. HIPAA Privacy Notices: BCN and the GHP are an “organized healthcare delivery system” with respect to protected health information (PHI), as those terms are defined in 45 C.F.R. § 164.500, created or received by BCN that relates to individuals who are or who have been participants or beneficiaries in the GHP. BCN will comply with the administrative requirements under 45 C.F.R. Parts 160 and 164 and prepare and distribute Notices of Privacy Practices appropriate for Group under 45 C.F.R. § 164.520. Group shall maintain the confidentiality of any PHI that may be disclosed by BCN.

12. Licensees Status of BCN. This Agreement is between Group and BCN, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCN is not an agent of BCBSA and, by entering into this Agreement, Group agrees that it made this Agreement based solely on its relationship with BCN or its agents. The Group further agrees that BCBSA is not a party to, nor has any obligations under this Agreement, and that no obligations are created or implied by this language.

13. Litigation. Any suit arising out of this Agreement or any Certificates and Riders must be filed within 2 years after the cause of action arose and, unless pre-empted by ERISA, shall be brought in a Michigan court of competent jurisdiction. Under no circumstances may Group, the GHP or a Member file suit before exhausting the internal BCN-administered steps of the applicable grievance procedure referenced in Section 8. However, exercising any rights under Section 8, shall not extend the 2-year period in which any suit may be filed.

14. Termination. Upon thirty (30) days written notice, either party may terminate this Agreement for any reason consistent with applicable law. BCN may also terminate this Agreement as described in Section 3 above.

Continued on Page 4
15. Assignment and Waiver. Neither party may assign this Agreement without the written permission of the other party. Any assignment by Group without BCN’s written permission shall be deemed a voluntary termination of this Agreement by Group. The waiver by a party of any breach of this Agreement by the other party shall not constitute a waiver of any subsequent breach of this Agreement.

The Group will immediately notify BCN in writing of any change in Group’s name, identity, ownership, or legal organizational structure, any change in, or addition to, a location of Group’s place of business, and any merger, combination, sale of assets, or other similar material transaction in which Group is involved. For purposes of this Agreement, a “Change in Control” shall be deemed to be an assignment requiring BCN’s consent and shall mean an event resulting in a change in the beneficial ownership of Group of 50% or more immediately after the event compared to one year before the event. “Beneficial ownership” means actual ownership or the right, directly or indirectly, to control voting power associated with ownership interests in Group.

16. Exclusions. Notwithstanding anything contained in this Agreement, BCN will have no obligation to Group for any coverage not specified in the applicable Certificate and Riders, nor for any coverage that Group, in whole or in part, contracts with other carriers to provide on behalf of the Group. Group agrees to indemnify and hold BCN harmless against any loss, claims, actions, and damages, including costs and reasonable attorneys’ fees, that may arise from any coverage not so provided by BCN.

17. Entire Agreement; Amendment. This Agreement, which, as defined, includes Parts A, B, and C, together with any attachments is the entire agreement between BCN and Group and supersedes all other agreements, oral or written, between the parties regarding the same subject matter. This Agreement may only be amended by written document signed by the parties, provided, however that this Agreement may be amended by BCN upon written notice to Group in order to facilitate compliance with applicable regulatory requirements, changes in regulations, or reporting requirements or data disclosure provided such amendment is applicable to all BCN Groups that would be similarly affected by the regulation in question.

BCN will provide thirty (30) calendar days notice of any such amendment and regulatory provision, unless a shorter notice is necessary in order to accomplish regulatory compliance.

Upon request by Group BCN will consult with Group regarding the regulatory basis for any amendment to this Agreement as a result of regulatory requirements.

18. Severability. If any provision of this Agreement is found invalid or unenforceable, the remaining provisions shall remain in full force and effect.

19. Governing Law. This Agreement is entered into in Michigan and, except as may be pre-empted by ERISA, shall be construed according to the laws of Michigan.

20. Quality Programs. Claims incurred by Enrollees include amounts that BCN reimburses health care providers, including reimbursement tied to enrollee in accordance with “Quality Programs,” which are governed by separate agreements with health care providers and are designed to improve health care outcomes and control health care costs. BCN has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCN does not unbundle claims and does not retain any component of claims as compensation.

BCN negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCN Quality Programs, including, for example, Pay-for-Performance rates and Value Based Contracting rates earned by hospitals and Patient Centered Medical Home rates earned by physicians. Providers may also receive reward and incentive payments from BCN Quality Programs funded through an allocation from provider reimbursement or other agreed upon methods. Such allocations may be to a pooled fund from which value-based payments to providers are made. For example, pursuant to the Physician Group Incentive Program (PGIP), physicians agree to allocate a percentage of each claim to a PGIP fund, which in turn makes reward payments to eligible physician organizations demonstrating particular quality and pays physician organizations for participation in collaborative initiatives.

Provider reimbursement rates also capture provider commitments to BCN Quality Programs. For example, hospitals participating in Hospital Collaborative Quality Initiatives agree to allocate a portion of their reimbursement to fund inter-hospital quality initiatives.

Value based reimbursement includes other obligations and entitlements pursuant to other Quality Programs funded in a similar manner to those described above. Additional information is available from BCBSM account representative representatives and at www.valuepartnerships.com.
21. Rating Methodology Type. As shown by checked box below Group is either Small Group rated or Large Group rated under Formula II or Formula III.

Small Group Rating
- □ Small Group Rating: Applies to groups of 50 or fewer eligible employees with 1 or more enrolled medical contracts. Groups of one enrolled must be an eligible employee.
- BCN Small Group Rating is an underwritten, modified community rating arrangement with member level rating as prescribed by the PPACA. No gains or losses are returned to or recovered from Group at renewal or at termination. There are no annual group settlements.

Large Group Rating
- □ Large Group Formula III – Applies to groups of 51 or more eligible employees.
  - Formula III is an experience rated and/or demographically adjusted underwritten arrangement where gains and losses are not returned to or recovered from Group at renewal or at termination.
  - No gains or losses are returned to or recovered from Group.
  - There are no annual settlement accounting or investment income credits or debits.
  - There is no Rate Stabilization Reserve (RSR) account.

The above descriptions of the small group and large group rating methodologies are summaries only and are not intended to be complete. As previously noted, coverage under this Agreement is subject to the terms of applicable Certificates and Riders, BCN’s administrative and underwriting requirements, the Guide, and the terms and conditions set forth in this Agreement.

22. Status Change Requests. Group represents that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including PPACA, and agrees that it will only request eligibility and status change requests that are compliant with and permissible under applicable state and federal law, including PPACA.

23. Compliance with Law; Penalties. Group agrees to abide by all applicable state and federal law, including but not limited to PPACA. Any penalties, excise taxes, or similar charges ("Penalties") imposed on Group or BCN for the failure of either to comply with PPACA shall be allocated between BCN and Group on a basis proportional to the respective fault of the parties with respect to such failure.

In the event that BCN pays any portion of the Penalties for which Group was responsible, Group shall indemnify and hold BCN harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from Group’s failure to pay such Penalties.

24. Group Disclosure of Other Coverage Vendors. Group agrees that, to the extent that BCN does not provide to GHP’s participants all “essential health benefits,” as defined by PPACA, Group shall identify for BCN all those vendors ("Vendors") that are also providing essential health benefits to GHP’s participants, the benefits the Vendors are providing to them, the number of participants receiving such benefits, and the cost sharing arrangements for such benefits. In addition, Group shall cause its officers, directors, employees, and representatives and Vendor’s officers, directors, employees, and representatives to fully and timely cooperate with BCN and provide it with the necessary information for BCN to (a) determine the correct medical loss ratio (MLR) and make such other determinations as are required by PPACA with respect to the GHP and (b) ensure its compliance and that of the GHP with PPACA to the extent BCN is obligated to do so by law or by contract. This information includes, but is not limited to, social security numbers or other forms of government identification numbers of each GHP participant.

Group authorizes all Vendors to, and shall inform the Vendors in Group’s contract with them that they must, effective on the beginning of Group’s first plan year on or after January 1, 2014, disclose to BCN on a daily basis (or some other regularly scheduled period as determined by BCN) all claims data for the essential health benefit(s) for GHP participants that they possess so that BCN may properly determine whether the maximum out-of-pocket amount is in compliance with PPACA.
25. Other Data Requirements. Group agrees to provide to BCN all data reasonably necessary for BCN to comply with the requirements of PPACA or any other applicable federal or state law. Such data includes, but is not limited to, data needed to comply with any reporting or other requirements of PPACA, e.g., the employer’s share of any premium and social security and tax identification numbers. Group certifies that if it fails to provide all the data in the manner requested and if it has provided such information to BCN in response to a previous request, then Group shall be deemed to have certified to BCN that such information previously supplied remains correct and can be relied upon.

Group and Group’s Vendors will maintain relevant books, records, policies, procedures, internal practices, and/or data logs relating to this Agreement in a manner that permits review for a period of seven (7) years following the expiration of this Agreement. With reasonable notice and during usual business hours, BCN, or its designated third party (with appropriate confidentiality obligations), may audit the relevant books, records, policies, procedures, internal practices, and/or data logs of Group and/or its Vendors, as necessary to verify calculations related to the imposition of any taxes and fees under PPACA or other federal or state laws and to ensure compliance with this Agreement and any applicable federal and state laws. Group shall cooperate with BCN in all reasonable respects in connection with such audits.

BCN’s failure to detect, fail to notify Group of detection, or fail to require Group’s remediation of any unsatisfactory practices, does not relieve Group of its responsibility to comply with this Agreement or applicable law, does not constitute acceptance of such practice, and does not constitute a waiver of BCN’s enforcement rights under this Agreement or applicable law.

If Group conducts, or contracts to have conducted, an internal audit or review of the services performed under any agreement with BCN, Group shall provide BCN with a copy of such audit or review within thirty (30) days of BCN’s written request. This also applies to audits/reviews performed by or at the request of any federal or state regulatory agencies of BCN services. The selection of an independent auditor by Group to conduct an internal audit of Group does not preclude BCN from conducting an audit in accordance with the terms contained herein.

The provisions of this Section shall survive the termination of this Agreement.

26. Group Health Plan Type; Medical Loss Ratio Rebate; Attestation. Concurrently with the signing of this Agreement and each renewal, Group will provide BCN with a written certificate in form and substance satisfactory to BCN certifying to BCN whether the Group is an ERISA plan, a non-federal governmental plan, or an ERISA-exempt church plan. If Group is an ERISA-exempt church plan, Group will provide BCN with an attestation, in form and substance satisfactory to BCN, providing written assurance to BCN that the medical loss ratio rebates, if any, will be used for the benefit of then current subscribers in a manner consistent with 45 CFR §156.242(b).

27. Grandfather Status; Women’s Preventive Care Religious Exemption. Group acknowledges and agrees that unless a written certificate of Group’s PPACA grandfather status and indemnity in form and substance satisfactory to BCN was previously provided to BCN by Group or, for a Group new to BCN as of January 1, 2013, was provided to and accepted by BCN concurrently with the signing of this Agreement, Group will be considered non-grandfathered for all purposes. Notwithstanding any other provision, groups of 50 or less eligible employees will be treated as non-grandfathered for all purposes.

In addition, Group acknowledges that the health care coverage provided to its Enrollees will include recommended women’s preventive health services without cost sharing (as required by PPACA) unless it (i) is a grandfathered group health plan that has not provided such coverage or (ii) qualifies as either an exempt group health plan or one eligible for the temporary safe harbor under PPACA and has provided a certificate to that effect in form and substance satisfactory to BCN.

28. Record Access. Group will maintain adequate operational, financial, and administrative records, contracts, books, files and other documentation directly or indirectly related to the performance undertaken by this Agreement (collectively referred to as “Records”). Such Records at a minimum shall be sufficient to enable BCN to enforce its rights under the Agreement, to determine whether the Agreement is being performed by Group in accordance with applicable laws, and for BCN compliance with laws as may be related to performance under this Agreement. Records also includes but is not limited to any records that pertain to any aspect of data reported to the Department of Health and Human Services or that pertain to rebate payments made and calculated under 45 Code of Federal Regulations Part 158, "Issuer Use of Premium Revenue: Reporting and Rebate Requirements" including but not limited to all administrative and financial books and records.

Group agrees that BCN and Government Authorities will have the right to access, audit, copy, evaluate, and inspect Records and that BCN and Government Authorities have the right to access all of Group personnel, premises, facilities, equipment and computers and other electronic systems to inspect, copy, evaluate and audit Group’s performance under the Agreement which pertains to any aspect of data reported to Department of Health and Human Services or that pertain to rebate payments made and calculated under 45 Code of Federal Regulations Part 158.

Group will provide immediate notice by telephone to be followed with written notice within three (3) business days, of receipt of any non-routine request from any Government Authority for records and/or access to Group’s personnel, premises, facilities, equipment and computers and other electronic systems. Group shall provide BCN with copies of all Records inspected, evaluated, and audited, including but not limited to all Records of which any Government Authority made copies.

The terms of this Section will remain in effect for the longer of ten years from (i) the termination of this Agreement, (ii) completion of the audit, or (iii) such other time frame as required by federal or state law or a Government Authority.
29. Summary of Benefits and Coverage (SBC). This provision only applies where Group and GHP are not exempt from federal SBC rules and regulations. BCN and Group agree to the following responsibilities for creation and distribution of SBCs:

BCN Responsibilities:

1. Creation. BCN shall create an SBC for each of Group’s applicable BCN coverages.
2. Distribution. BCN shall provide Group with an SBC for applicable Group coverages as follows:
   • Group Quotes. BCN will provide the applicable SBC with a Group quote to Group or to Group’s Agent, as the case may be, upon request where Group or Group’s Agent requests a quote from BCN.
   • Website Posting. BCN will post Member SBCs for applicable BCN coverage to the Member Secured Services website. BCN may post SBCs to Group Secured Services and Agent Secured Services websites. In the event BCN posts SBCs to Group Secured Services website, BCN will provide notice to Group.
   • Renewal. BCN will provide Group, either directly or through Group’s Agent, with a renewal package containing the applicable SBC.
   • Upon Request. BCN will, upon request from a participant or beneficiary, provide him/her with the SBC for the coverage in which he/she is enrolled. BCN will provide Group with applicable SBCs for BCN coverages upon Group request.
3. SBC Update. BCN will seasonally update Group SBCs for applicable BCN coverages following a change in BCN coverage or in the context of a Notice of Material Modification affecting a previously issued SBC for BCN coverage.

Group Responsibilities:

1. Dissemination. Group shall be solely responsible for disseminating an electronic copy (via the internet or otherwise) or a paper copy of the applicable SBC to participants and beneficiaries (including pre-enrollees) in a manner compliant with (a) the Employee Retirement Income Security Act (ERISA, as amended), if applicable; (b) all the requirements of Section 2715 of the Public Health Service Act (PHSA) as added by Section 1001 of PPACA; (c) any applicable regulations implementing PHSA Section 2715 codified in the Code of Federal Regulations; and, (d) any sub-regulatory guidance regarding PHSA Section 2715. The circumstance under which Group shall provide an SBC to participants and beneficiaries, within the time permitted by law, include but may not be limited to upon request, application, open enrollment, renewal, special enrollment, and change in coverage between application and effective date of coverage.
2. Delivery to Agent. Group agrees that if it has an Agent for renewal, BCN can deliver the SBC to Agent electronically or in print form, and such delivery to the Agent will be delivery to Group.
3. Updated Information. In advance of the next renewal year, within the time period designated by BCN, Group shall provide BCN with all necessary benefit information to enable BCN to provide Group applicable SBCs as required by this Agreement.
4. Updated SBC with Notice of Material Modification. Group agrees that it will provide an updated SBC to its participants and beneficiaries in accordance with the requirements set forth in the statutes and regulations where there is a Notice of Material Modification.
5. Notice of Failure to Deliver. Group will notify BCN immediately if it fails to deliver the SBC to participants and beneficiaries.
6. Correction of Known Violation. Group agrees that it will correct any known violation of the SBC rules as soon as practicable if it has information to do so; and, if it does not have the information necessary to make the correction, communicates with participants and beneficiaries regarding any violation and take steps to prevent future violations.
7. Electronic Distribution of SBC. Group agrees to promptly register for Group Secured Services website by visiting bcbsm.com and completing the registration process. BCN will notify Group if BCN posts SBCs to Group Secured Services website. Group consents to and agrees that delivery of any applicable SBC by BCN may be through Group’s Secured Services website. BCN will provide a print copy of any applicable SBC to Group free of charge upon request. SBCs posted by BCN to Group’s Secured Services website will be updated as required and previous versions may be removed by BCN.
8. Group Internal Intranet Website. Group agrees that if it provides participants and beneficiaries access in an electronic medium to BCN SBCs through Group’s internal intranet or by similar means that electronic access will be to a “read-only” SBC but in a readily accessible form which can be retained and printed, and that it will timely post updated SBCs as may be provided by BCN and to timely remove previous versions which have been updated.
9. Group Receipt of SBC. Group acknowledges that SBCs for applicable BCN coverage have been provided either prior to or concurrently with BCN’s delivery of this Agreement for signature by Group.
10. Indemnity. Group shall indemnify and hold BCN harmless against loss, claim or action, including costs, penalties and reasonable attorney fees, arising from Group’s failure to deliver the SBCs as described above.
11. Notice of Material Modification. Group has sole responsibility to provide written notice to enrollees of any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, and Group agrees that such notice will be provided not later than 60 days prior to the date on which the modification will become effective.

30. Copayments - BlueCard Program. Exhibit 1 attached to this Agreement describes the BlueCard Program available through the BCBSA. If the BCBSA revises the disclosure in Exhibit 1, BCN will give Group notice with a new Exhibit 1, which will automatically become part of this Agreement sixty (60) days after notice has been given.
I. Out-of-Area Services

BCN has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside the geographic area BCN serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to BCN for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the geographic area BCN serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from non-participating healthcare providers. BCN’s payment practices in both instances are described below.

BCN covers only limited healthcare services received outside of Michigan. As used in this Exhibit 1, “Out-of-Area Covered Healthcare Services” include emergency and urgent services obtained outside of Michigan. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless these “other services” are pre-authorized by Member’s primary care physician (“PCP”) or are routine and follow-up care provided by a participating provider in another Blue Plan’s network.

A. BlueCard® Program

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, BCN will remain responsible to Group for fulfilling BCN’s contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description, however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member’s liability for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider’s billed covered charges or the negotiated price made available to BCN by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s healthcare provider contracts. The negotiated price made available to BCN by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment 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 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 covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare 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.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is the final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCN is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCN would then calculate Member liability in accordance with applicable law.
Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable InterPlan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

B. Non-Participating Healthcare Providers Outside BCN’s Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of BCN’s service area by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue’s non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment BCN will make for the covered services as set forth in this paragraph.

2. Exceptions

In some exception cases, BCN may pay claims from non-participating healthcare providers outside of BCN’s service area based on the provider’s billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by BCN in BCN’s sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if BCN were paying a non-participating provider inside of BCN’s service area, as described elsewhere in this Agreement, where the Host Blue’s corresponding payment would be more than BCN’s in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment BCN will make for the covered services as set forth in this paragraph.
New Group - Part B

<table>
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<tr>
<th>Sponsored Plan Acronym</th>
<th>Customer ID (BCBSM), Group ID (BCN)</th>
<th>SubGroup ID</th>
<th>Class ID</th>
<th>BCBSM Group Number</th>
<th>Group Division</th>
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<table>
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<td>County</td>
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<tr>
<td>State</td>
<td></td>
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<tr>
<td>Zip Code</td>
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<td>Primary Nature Of Business</td>
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<td>DBA</td>
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<td>Doing Business As</td>
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<td>Company Fax</td>
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Check here if this group is ERISA Exempt [X]  
Are you currently in bankruptcy? [X] Yes [ ] No  
Do you have any leased employees? [X] Yes [ ] No  
Does this group have subsidiaries, offices, or branches located at other physical locations? [X] Yes [ ] No  
If yes, submit multiple location report

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<th>Is Work Force Unionized?</th>
<th>Number of Employees Represented</th>
<th>Local Number</th>
<th>Contract Expiration Date</th>
<th>National / International Name</th>
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<tbody>
<tr>
<td>[X] Yes [ ] No</td>
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Local Representative Name | | Employer Monthly Contributions: |
|--------------------------|--------------|

A. To be eligible for coverage, an employee must work a minimum of 30 hours per week.
B. Eligible Dependent coverage will be effective on date of event, e.g., spouse, newborn, if written notification is received within 31 days thereof with billing prorated.
If after 31 days, coverage will be effective at group’s next annual reopening date.
C. Enter appropriate BCBSM/BCN code selected from the New Hire/Retire options table for newly hired full-time employees, or part-time employees who become full-time. Any requests that do not comply with BCBSM/BCN guidelines require underwriting review and approval, such as requests from large employers related to compliance with the employer mandate provisions of IRC 4980H.  
Employees hired with an active BCBSM/BCN contract may transfer to this group without regard to above schedule (Item C, above).
D. Exceptions: |

Managing Agent Name | |
Agent Name (first and last) | | MA Code | Agent Code |

ID cards will be mailed directly to the subscriber unless the box below is checked.
Mail to group [X] Yes

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<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tr>
<td>New Group - Part B</td>
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<td>Previous or existing BCBSM/BCN Coverage?</td>
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<td>If Yes, Former Group Number</td>
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<td>Billing Contact Information</td>
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<td>Billing Contact - Phone Number</td>
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<td>Billing Contact - Job Title</td>
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<td>City</td>
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<td>City</td>
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<td>Administrative Contact Information</td>
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<td>Mailing Address</td>
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<td>Chief Executive Contact Information</td>
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<tr>
<td>Chief Executive - First Name</td>
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<td>Chief Executive - Last Name</td>
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<td>Chief Executive's Phone Number</td>
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<tr>
<td>Chief Executive's Phone Number</td>
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New Group - Part B

The person named below has full legal authority to execute agreements on behalf of your company and is authorized to delegate access to all of your group's information available through our website.

<table>
<thead>
<tr>
<th>Name of Principal Administrator you wish to appoint (could be self):</th>
<th>First Name</th>
<th>Last Name</th>
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<tbody>
<tr>
<td>Principal Administrator's email address:</td>
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Billing and Contact Email Information for record updates

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<thead>
<tr>
<th>Chief Executive’s email address:</th>
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<tr>
<td>Billing Contact Person’s email address:</td>
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<td>Administrative Contact Person’s email address:</td>
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Designated Mutual Voter Contact Information (BCBSM Only)

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<tr>
<th>Name of Mutual Voter you wish to appoint (could be self):</th>
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<tr>
<td>Mailing Address:</td>
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<td>State</td>
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<td>Zip Code</td>
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Federal Tax ID Number

Group Exec Initials
### BCBSM/BCN
#### New Hire/Rehire Options

<table>
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<tr>
<th>New Hire/Rehire Option</th>
<th>BCBSM Code</th>
<th>BCN Code</th>
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<tr>
<td>The employee coverage will be effective the date of hire/rehire.</td>
<td>S2</td>
<td>01</td>
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<tr>
<td>The employee coverage will be effective the first billing date following the date of hire/rehire.</td>
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<td>16</td>
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<td>The employee coverage will be effective the 31st day from the date of hire/rehire</td>
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* Enter appropriate code for New Hire/Rehire Options in item C on the first page of part B
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<th>Product</th>
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<th>Deductible</th>
<th>Co-Insurance</th>
<th>Embedded Co-Insurance</th>
<th>OOP Max</th>
<th>Employer HRA/HSA Contribution</th>
<th>Copay (OV/Spec/UC/ER)</th>
<th>Rx-Includes MOPD3x-$10 and Contraceptives</th>
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<td></td>
<td>HMO Platinum 20%</td>
<td>$0</td>
<td>20%</td>
<td>$1,000</td>
<td>$6,600</td>
<td>$0</td>
<td>$25/$35/$50/$80/20%</td>
<td>$4/$5/$40/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Platinum 20% with CDL*</td>
<td>$0</td>
<td>20%</td>
<td>$1,000</td>
<td>$6,600</td>
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<td>$25/$35/$50/$80/20%</td>
<td>$4/$5/$40/$80/20%/20%</td>
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<tr>
<td></td>
<td>HMO Gold 30%</td>
<td>$0</td>
<td>30%</td>
<td>$5,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$30/$40/$50/$80/20%</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Platinum $500</td>
<td>$500</td>
<td>0%</td>
<td>n/a</td>
<td>$1,000</td>
<td>$0</td>
<td>$20/$30/$35/$50/$150</td>
<td>$4/$5/$40/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Platinum $500 with CDL*</td>
<td>$500</td>
<td>0%</td>
<td>n/a</td>
<td>$1,000</td>
<td>$0</td>
<td>$20/$30/$35/$50/$150</td>
<td>$4/$5/$40/$80/20%/20%</td>
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<tr>
<td></td>
<td>HMO PCP Focus Platinum $500</td>
<td>$500</td>
<td>0%</td>
<td>n/a</td>
<td>$1,000</td>
<td>$0</td>
<td>$20/$30/$35/$50/$150</td>
<td>$4/$5/$40/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Gold $500/10%</td>
<td>$500</td>
<td>10%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Gold $1000</td>
<td>$1,000</td>
<td>20%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO PCP Focus Gold $1000</td>
<td>$1,000</td>
<td>20%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Gold $1500</td>
<td>$1,500</td>
<td>20%</td>
<td>$1,500</td>
<td>$6,600</td>
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<td>$10/$30/$50/$20%/20%</td>
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<tr>
<td></td>
<td>HMO PCP Focus Gold $1500</td>
<td>$1,500</td>
<td>20%</td>
<td>$1,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Gold $2000</td>
<td>$2,000</td>
<td>30%</td>
<td>$1,000</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO PCP Focus Gold $2000</td>
<td>$2,000</td>
<td>30%</td>
<td>$1,000</td>
<td>$6,600</td>
<td>$0</td>
<td>$20/$40/$50/$150</td>
<td>$10/$30/$50/$20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Silver $3000</td>
<td>$3,000</td>
<td>20%</td>
<td>$3,500</td>
<td>$6,600</td>
<td>$0</td>
<td>$30/$50/$80/$20%</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO PCP Focus Silver $3000</td>
<td>$3,000</td>
<td>20%</td>
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<td>$6,600</td>
<td>$0</td>
<td>$30/$50/$80/$20%</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Silver $4000/100%</td>
<td>$4,000</td>
<td>0%</td>
<td>n/a</td>
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<td>$6,600</td>
<td>$0</td>
<td>$35/$45/$50/$250</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO PCP Focus Silver $4000</td>
<td>$4,000</td>
<td>30%</td>
<td>$2,000</td>
<td>$6,600</td>
<td>$0</td>
<td>$35/$45/$50/$250</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td>BCN HRA</td>
<td>HMO Platinum $1500</td>
<td>$1,500</td>
<td>20%</td>
<td>$500</td>
<td>$6,350</td>
<td>$750</td>
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<td>HMO Platinum $2000</td>
<td>$2,000</td>
<td>20%</td>
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<tr>
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<td>HMO Gold $2000</td>
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<td>20%</td>
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<tr>
<td></td>
<td>HMO Gold $4000</td>
<td>$4,000</td>
<td>20%</td>
<td>$4,000</td>
<td>$6,350</td>
<td>$1,000</td>
<td>$30/$50/$80/$150</td>
<td>$4/$5/$40/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO Platinum $5000</td>
<td>$5,000</td>
<td>20%</td>
<td>$n/a</td>
<td>$6,350</td>
<td>$3,500</td>
<td>$35/$45/$50/$250</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
<tr>
<td></td>
<td>HMO PCP Focus Platinum $5000</td>
<td>$5,000</td>
<td>20%</td>
<td>$n/a</td>
<td>$6,350</td>
<td>$3,500</td>
<td>$35/$45/$50/$250</td>
<td>$6/$25/$50/$80/20%/20%</td>
</tr>
</tbody>
</table>

* Comprehensive Drug List
## 2016 Small Group Menu

### New Business

#### Part C - (continued)

<table>
<thead>
<tr>
<th>Group Name (Full Legal Name)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Exec Initials</th>
<th>Federal Tax Id</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group ID</th>
<th>Sub Group ID</th>
<th>Class ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Product

#### Healthy Blue Living

<table>
<thead>
<tr>
<th>Plans</th>
<th>Dedicated</th>
<th>Co-Insurance</th>
<th>Embedded Co-Insurance Maximum</th>
<th>OOP Max</th>
<th>Employer HRA/ HSA Contribution</th>
<th>Copay (OV/Spec/UC/ER)</th>
<th>Rx-Includes MOPD3x-$10 and Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Platinum $250</td>
<td>Enhanced</td>
<td>$250</td>
<td>20%</td>
<td>$500</td>
<td>$6,600</td>
<td>0</td>
<td>20/30/35/150</td>
</tr>
<tr>
<td>Standard</td>
<td>$1,500</td>
<td>30%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>0</td>
<td>30/40/35/150</td>
<td></td>
</tr>
<tr>
<td>HMO Platinum $500</td>
<td>Enhanced</td>
<td>$500</td>
<td>0%</td>
<td>n/a</td>
<td>$1,000</td>
<td>0</td>
<td>20/30/35/150</td>
</tr>
<tr>
<td>Standard</td>
<td>$3,000</td>
<td>30%</td>
<td>$3,500</td>
<td>$6,600</td>
<td>0</td>
<td>30/40/35/150</td>
<td></td>
</tr>
<tr>
<td>HMO Gold $1000</td>
<td>Enhanced</td>
<td>$1,000</td>
<td>20%</td>
<td>$2,000</td>
<td>$6,600</td>
<td>0</td>
<td>25/35/35/150</td>
</tr>
<tr>
<td>Standard</td>
<td>$3,000</td>
<td>30%</td>
<td>$3,000</td>
<td>$6,600</td>
<td>0</td>
<td>30/40/35/150</td>
<td></td>
</tr>
<tr>
<td>HMO Gold $1500</td>
<td>Enhanced</td>
<td>$1,500</td>
<td>20%</td>
<td>$1,500</td>
<td>$6,600</td>
<td>0</td>
<td>20/30/35/150</td>
</tr>
<tr>
<td>Standard</td>
<td>$4,000</td>
<td>30%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>0</td>
<td>35/45/55/250</td>
<td></td>
</tr>
<tr>
<td>HMO Gold $2000</td>
<td>Enhanced</td>
<td>$2,000</td>
<td>20%</td>
<td>$1,000</td>
<td>$6,600</td>
<td>0</td>
<td>25/35/35/150</td>
</tr>
<tr>
<td>Standard</td>
<td>$4,000</td>
<td>30%</td>
<td>$2,000</td>
<td>$6,600</td>
<td>0</td>
<td>35/45/56/250</td>
<td></td>
</tr>
</tbody>
</table>

#### Blue Elect Plus

| Self Referral Option Gold $1000 | $1,000 | 20% | $2,500 | $6,600 | 0 | 20/40/50/150 |

#### BCN HSA

| HMO Gold $1300 | $1,300 | 20% | n/a | $2,300 | 0 | Ded/coinsurance |
| HMO Gold $1350/0% | $1,350 | 0% | n/a | $2,350 | 0 | Ded/coinsurance |
| HMO Gold $2700/0% | $2,700 | 0% | n/a | $5,000 | 700 | Ded/coinsurance |
| HMO Silver $2700 | $2,700 | 20% | n/a | $5,000 | 700 | Ded/coinsurance |
| HMO Silver $3000/0% | $3,000 | 0% | n/a | $6,350 | 0 | Ded/coinsurance |
| HMO Bronze $4500 | $4,500 | 30% | n/a | $6,450 | 0 | Ded/coinsurance |
| HMO PCP Focus Bronze $4500 | $4,500 | 30% | n/a | $6,450 | 0 | Ded/coinsurance |
| HMO Bronze $6350/0% | $6,350 | 0% | n/a | $6,350 | 0 | Ded/coinsurance |
| HMO PCP Focus Bronze $6350/0% | $6,350 | 0% | n/a | $6,350 | 0 | Ded/coinsurance |

#### Routine Care

| HMO Silver $1500 | $1,500 | 30% | n/a | $6,350 | 0 | 40/Ded/Ded/Ded |
| HMO Silver $3000 | $3,000 | 20% | n/a | $5,000 | 0 | 30/Ded/Ded/Ded |

### Additional Information

- Include Elective Abortion Coverage (available with all plans)
- Are you using HealthEquity to coordinate your HSA? (response required)  
  - Yes  
  - No

---

PCP Focus Counties (Employer groups must be located in Bay, Calhoun, Clinton, Eaton, Genesee, Ingham, Kalamazoo, Kent, Livingston, Macomb, Monroe, Muskegon, Oakland, Ottawa, Saginaw, Shiawassee, St. Clair, Van Buren, Washtenaw, and Wayne counties.)

Page 15 of 19, 10012016 BCNC GWC Small Group
2016 Small Group Menu
New Business
Part C - (continued)

☐ Stand Alone BCN Advantage Enrollment (do not choose a commercial medical or RX plan, stand alone BCNA requires 5+ enrolling)

<table>
<thead>
<tr>
<th>Medicare Options</th>
<th>BCN Advantage</th>
<th>Medical Plan (Deduct/Coins/ECM/OOPM/OV)</th>
<th>Drug Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ BCN65</td>
<td>(complete for BCN Advantage only)</td>
<td>☐ None</td>
<td>☐ $15/50/60% ($70/100)</td>
</tr>
<tr>
<td>☐ BCN Advantage</td>
<td></td>
<td>☐ $10/80</td>
<td>☐ $15/50/60%/$20/20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ $10/40</td>
<td>☐ $20/60/50/$80/100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ $15/60</td>
<td>☐ $20/60/20%/$80/20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ $10/80/$40</td>
<td>☐ $20/80/20%/$80/20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ $10/40/$80/20%/20%</td>
<td>☐ 20% ($5/$100)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ $10/80/20%/20%</td>
<td>☐ 50% ($5/$100)</td>
</tr>
</tbody>
</table>

☐ Statements of Prior Deductibles Included

<table>
<thead>
<tr>
<th>Blue Vision&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Blue Vision</th>
<th>Blue Vision Visionary</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12-12, $5/10</td>
<td>12-12-12</td>
<td>12-12-12, $10/25</td>
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<tr>
<td>12-24-24, $5/10</td>
<td>12-12-24</td>
<td>12-12-24, $80/25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Dental&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Non-Voluntary - PPO (Non-PPO)</th>
<th>Annual Max - PPO (Non-PPO)</th>
<th>Annual Max - PPO (Non-PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO Plus 100/80/50</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$1,000</td>
</tr>
<tr>
<td>PPO Plus 80/50/50</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>PPO 100/80/50 (80/50/50)</td>
<td>$1,250 ($800)</td>
<td>$1,000 ($800)</td>
<td>$1,250 ($800)</td>
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<tr>
<td>PPO 80/50/50 (50/50/50)</td>
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<td>$1,000</td>
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<tr>
<td>EPO 100/80/50</td>
<td>$800</td>
<td>$1,000 ($800)</td>
<td>$1,250 ($800)</td>
</tr>
</tbody>
</table>

☐ Third party pediatric dental coverage. Requires dental coverage attestation.

☐ Waive Waiting Period (Proof of prior dental coverage required)

Selecting a Voluntary dental plan requires completion of the dental coverage attestation.

☐ 50% Ortho (Employer Paid - lifetime max matches in-network annual max, Voluntary - lifetime max is $1,000, except EPO 100/80/50 is $1,250)
## New Group - Part C (con’t)

**Complete the applicable section for all New Business or previously unenrolled**

<table>
<thead>
<tr>
<th>Total Group Census</th>
<th>Medical Enrolling</th>
<th>Medical Not Enrolling</th>
<th>Dental Enrollment</th>
<th>Vision Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue Enrolled - Active</td>
<td>Other Enrolled - Other Segment</td>
<td>Other Enrolled - Identify Segment - Other Enrollment</td>
<td>Other Enrolled - Other Enrollment</td>
</tr>
<tr>
<td></td>
<td>Ineligible - Part Time</td>
<td>Other Enrolled - Identify Segment i.e., Union/NHWP</td>
<td>Other Enrolled - Other Enrollment</td>
<td>Other Enrolled - Other Enrollment</td>
</tr>
<tr>
<td></td>
<td>Total Employees</td>
<td>Enrolled Other Carrier</td>
<td>Enrolled Other Carrier</td>
<td>Enrolled Other Carrier</td>
</tr>
<tr>
<td></td>
<td>Eligible - Employees</td>
<td>WAIVING Coverage</td>
<td>WAIVING Coverage</td>
<td>WAIVING Coverage</td>
</tr>
</tbody>
</table>

*Note: Enrolling plus Not Enrolling segments equal “Eligible Employees.” Segments not enrolling (e.g., Union/NHWP) captured in the “Not Enrolling” section are still counted towards determining group’s rating type.*

### For BCBSM/BCN Managing Agent Use Only

- **Effective Date:**
  - Sales Office Code:
  - Control Code:
- **Billing Cycle Date:**
  - Mail Code:
  - SIC Code:
- **Rate Renewal / Plan Year Date:**
  - Territory Code:
  - County Code:
- **Open Enrollment Date:**
  - Cluster Code:

- **Group has a Retiree Segment?**
  - □ Yes    □ No
  - **MA Contact Person:**
  - **Phone Number:**

**Comments:**

---

**Page 17 of 19, Part C, October 1, 2016**
New Group Attestation Form
Medical Loss Ratio Reporting Period

Federal Tax Id

Group Name

Please provide the following information:

1. Employee count. Please provide the average number of active (non-retiree) employees in your company on business days during the most recently completed calendar year. Include full-time, part-time and seasonal workers whether or not they are eligible for health insurance benefits. To calculate this number:
   - Count the number of full-time, part-time and seasonal employees for the business days each month, add them and divide by 12.
   - Round the average number up or down to the nearest whole number.

In accordance with federal law and regulations, sole proprietors and their spouses should not be included in the employee count.

Most recently completed calendar year

Employee count for most recently completed calendar year

2. Sole proprietor status: Please check one of the following:
   - I am not a sole proprietor (or sole shareholder).
   - I am a sole proprietor (or sole shareholder) and my employee(s) are enrolled in medical health care coverage that I sponsor (with BCBSM/BCN or elsewhere).
   - I am a sole proprietor (or sole shareholder) and my employee(s) are not enrolled in medical health care coverage that I sponsor (with BCBSM/BCN or elsewhere).

3. Group Health Plan Type. Your group health plan status will fall into one of the following three options. Please check the appropriate option. If you are an ERISA-exempt church plan (as described below) you must also choose one of the rebate distribution options:
   - Group health plan is an employee benefit plan established or maintained by an employer or employee organization (such as a union) that provides medical, surgical or hospital care for participants or their dependents directly or through insurance reimbursement.
   - Group health plan is a nonfederal government plan established or maintained by employees government by state government, political subdivision of state government, or any agency or instrument of any of these.
   - Group health plan is an ERISA-exempt church plan (a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches exempt from tax under section 501 of Title 26 (26 USC 10025 (33)(A)).

ERISA-exempt church plans rebate options. Please check one of the following:
   - The plan agrees to use any rebate issued for the benefit of the group health plan subscribers in accordance with 45 CFR §158.242. By checking this box, any applicable rebate will be sent to the group. (Note: if we do not receive this attestation, federal law requires BCBSM/BCN to distribute any rebates directly to the enrollees of the group health plan covered by the policy during the MLR reporting year. Each enrollee will receive an equal share without regard to how much each enrollee actually paid toward premiums.)
   - The plan does not agree to use any rebate issued for the benefit of the group health plan subscribers.

BCBSM/BCN will distribute any applicable rebates in good faith based on this attestation. BCBSM/BCN will be held harmless for any losses that result from action taken based on this group attestation.

I am authorized by ______________________, sponsor of the group health plan described above. I attest that the employee counts provided above and the group health plan information are complete and accurate.

Name (print):

Title:

Signature:

Date:

If you would like future surveys sent to you via email, please provide your email address: ______________________

January 2017

BCN Group Enrollment Agreement
bcbsm.com
Group Inquiry: 1-800-970-6684
IMPORTANT NOTICE OF SMALL GROUP REIMBURSEMENT POLICY

The Patient Protection and Affordable Care Act, as amended (PPACA), and related federal and state regulations require BCBSM's and BCN's underwritten Small Group Products to be filed and approved with specified Actuarial Values (AV) or "metal levels." The AV of such products, including those used with an employer-funded health reimbursement arrangement (HRA) or health savings account (HSA), may be impacted if an employer contributes to a Member's policy, HRA, or HSA an amount that differs from that shown on Part C of the Group Enrollment and Coverage Agreement (Part C). Should an employer do so, BCBSM or BCN may refuse to sell the plan to the employer.

Group may permit employee-funded flexible spending accounts (FSAs) for any plan, provided, however, that Group FSA contributions may not exceed $250 per contract, with the following exceptions: BCBSM's Healthy Blue Achieve and BCN's Healthy Blue Living.

Deductibles, co-insurance or copays for non-HSA or non-HRA plans cannot be reimbursed except as specified in Part C.
### Identification numbers

**Group ID**

Your assigned 16-digit group number appears on the final copy of your Group Letter of Agreement and on your billing invoice. It consists of the following elements:

- **An eight-digit number**
  This number represents your group’s headquarters.

- **A four-digit subgroup number**
  Your group will have at least one subgroup. You may have additional subgroups if your group has multiple physical locations, different rating variables or if you request an additional billing breakdown.

- **A four-digit class ID**
  This represents the various categories of the employees you have within your group (salary, hourly or retiree).

### When to use the group ID

You must use the complete 16-digit group number to ensure accurate and prompt processing of membership changes and premium payments. Always have the number available when calling a Blue Care Network or Blue Cross Blue Shield of Michigan service area and include it in all written correspondence.

### Member ID cards

All subscribers receive an identification card. If there are two or more members on a contract, BCN sends two ID cards to the subscriber.

The ID card displays important coverage information that health providers need whenever the individual receives services. Members should carry their ID card at all times.

Only enrolled members are eligible to present ID cards for services.

Members who need new cards or duplicate cards can request them by logging into their account at [bcbsm.com](http://bcbsm.com). They can also call Customer Service, using the main number 1-800-662-6667, or the number on the back of their ID card.
## Group information change guidelines

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Contact</th>
<th>Frequency</th>
<th>Time Frame</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit level</strong></td>
<td>Blues sales representative or agent</td>
<td>Once every 12 months</td>
<td>At least 45 days prior to requested effective date</td>
<td>✓ Group Enrollment and Coverage Agreement — Part C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(not allowed 150 days prior to renewal date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tax ID number</strong></td>
<td>Blues sales representative or agent</td>
<td>As often as necessary</td>
<td>Immediately</td>
<td>✓ Group Enrollment and Coverage Agreement — Parts A, B, C &lt;br&gt; ✓ Copy of sale of business (if applicable)</td>
</tr>
<tr>
<td><strong>Group address or worker’s compensation number</strong></td>
<td>Blues sales representative or agent</td>
<td>As often as necessary</td>
<td>Immediately</td>
<td>✓ Letter from the group</td>
</tr>
<tr>
<td><strong>Group Contact Change</strong></td>
<td>BCN Group Inquiry or Blues sales representative or agent</td>
<td>As often as necessary</td>
<td>Immediately</td>
<td>✓ Letter from group</td>
</tr>
<tr>
<td>✓ Decision maker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Billing contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group eligibility requirements</strong></td>
<td>Blues sales representative or agent</td>
<td>Once every 12 months or at renewal</td>
<td>At least 45 days prior to requested effective date</td>
<td>✓ Letter from group stating previous policy and requested revisions or Group Enrollment and Coverage Agreement — Part B</td>
</tr>
</tbody>
</table>
### Group information change guidelines (continued)

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Contact</th>
<th>Frequency</th>
<th>Time Frame</th>
<th>Required Documentation</th>
</tr>
</thead>
</table>
| **New subgroup/class**       | Blues sales representative or agent          | As often as necessary | At least 45 days prior to requested effective date | ✓ Group Enrollment and Coverage Agreement — Parts B, C  
✓ Enrollment Application form  
✓ Copy of formal retirement program, if applicable |
| ✓ Salaried                     |                                              |                    |                                 |                                                                                        |
| ✓ Union                        |                                              |                    |                                 |                                                                                        |
| ✓ Retirees                     |                                              |                    |                                 |                                                                                        |
| **Special open enrollment**   | Blues sales representative or agent          | Exception — if approved by BCN Rating and Underwriting | At least 45 days prior to requested effective date | ✓ Letter from group with rationale for request |
| **Rate renewal or inventory date** | Blues sales representative or agent | Exception — if approved by BCN Rating and Underwriting | At least 45 days prior to requested effective date | ✓ Letter from group with rationale for request |
| **Business name change**      | Blues sales representative or agent          | As often as necessary | Immediately                    | ✓ Letter from group                                                                     |
## Enrollment and participation

### When to submit enrollment documents

Enrollment documents constitute the terms and agreements between BCN and your group. Submit all to your Blues sales representative or your independent agent according to the following schedule:

- For new business, at least 30 calendar days before your effective date
- For groupwide changes, at least 45 calendar days before your effective date

### Eligibility guidelines

Eligible employees, according to federal regulations, work full-time with a normal workweek of 30 or more hours. You may also choose to include part-time workers, those working 17.5 hours to 30 hours, as long as this eligibility criterion is applied uniformly without regard to health-related factors.

Enrollment requirements are determined by the total number of eligible individuals in your group as recorded on your payroll record in the current and preceding calendar years.

### Participation requirements

- **Groups of 10 or Fewer Eligible Employees**
  - 100 percent of all eligible individuals must enroll with BCN.

- **Groups of 11-25 Eligible Employees**
  - 75 percent of all eligible individuals must enroll with BCN and/or BCBSM.

- **Groups of 26-50 Eligible Employees**
  - 50 percent of all eligible individuals must enroll with BCN and/or BCBSM.
Benefit packages

What’s in a benefit package
You design your group’s benefit package with your independent agent or a BCBSM sales representative. A benefit package consists of one medical plan and, if you choose, an ancillary plan (for example, dental or vision) from those available. Groups with 50 or fewer full time equivalent employees must include pharmacy, pediatric dental and pediatric vision in their plans.

Groups that include ancillary coverage in a benefit package must include the same ancillary product in each benefit package they offer. The ancillary benefit level may vary with each package.

Benefit package options
The number of benefit packages available to you is based on the total number of BCN and BCBSM medical contracts enrolled in your group, excluding COBRA and retiree subscribers. A minimum of two contracts must enroll in each BCN benefit plan. Healthy Blue Living products cannot be offered with any other BCN product.

✓ 1-10 enrolled BCN/BCBSM medical contracts (excludes COBRA and retirees)
  One BCN benefit package¹

✓ 11-24 enrolled BCN/BCBSM medical contracts (excludes COBRA and retirees)
  No more than two BCN/BCBSM benefit packages in total

✓ 25-49 enrolled BCN/BCBSM medical contracts (excludes COBRA and retirees)
  No more than two BCN/BCBSM benefit packages in total²

✓ 50+ enrolled BCN/BCBSM medical contracts (excludes COBRA and retirees)
  No more than three BCN/BCBSM benefit packages in total

¹BCN groups with employees residing outside the BCN service area may add a BCBSM option to accommodate these out-of-service employees.

²Three plans may be offered when all eligible employees are enrolled with BCN or BCBSM.

Benefit changes
To register benefit changes, work with your Blues sales representative or independent agent to fill out the Group Enrollment and Coverage Agreement Benefit Change – Part C form. See sample on the next page.
## 2016 Small Group Menu

### Benefit Change

<table>
<thead>
<tr>
<th>Group Name (Full Legal Name)</th>
<th>Group Exec Initials</th>
<th>Federal Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Group ID</th>
<th>Sub Group ID</th>
<th>Class ID</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Requested Effective Date</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td></td>
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### Plans and Products

<table>
<thead>
<tr>
<th>Product</th>
<th>Plans</th>
<th>Deductible</th>
<th>Co-Insurance</th>
<th>Embedded Co-Insurance Maximum</th>
<th>OOP Max</th>
<th>Employer HRA/HSA Contribution</th>
<th>Copay (OV/Spec/UC/ER)</th>
<th>Rx Includes MOPD3x $10 and Contraceptives</th>
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<tbody>
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<td>BCN HMO</td>
<td>HMO Platinum 10%</td>
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<td>10%</td>
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<td>$5,000</td>
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<td>HMO Gold 30%</td>
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<td>30%</td>
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<td>6/25/$50/$40/$80/20%</td>
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<td>BCN HRA</td>
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<tr>
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<td>20%</td>
<td>n/a</td>
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<td>HMO PCP Focus Platinum $5000</td>
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<td>$3,350</td>
<td>$20/$40/$50/$50/$150</td>
<td>4/15/40/80/20%</td>
</tr>
</tbody>
</table>

* Comprehensive Drug List.
## 2016 Small Group Menu

### Benefit Change (continued)

<table>
<thead>
<tr>
<th>Product</th>
<th>Plans</th>
<th>Deductible</th>
<th>Co-Insurance</th>
<th>Embedded Co-Insurance Maximum</th>
<th>OOP Max</th>
<th>Employer HRA/ HSA Contribution</th>
<th>Copay (OV/Spec/UC/ER)</th>
<th>Rx-Includes MOPDdx-$10 and Contraceptives</th>
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</thead>
<tbody>
<tr>
<td><strong>Healthy Blue Living</strong></td>
<td>HMO Platinum $250</td>
<td>$250</td>
<td>20%</td>
<td>$500</td>
<td>$6,600</td>
<td>$20/$30/$35/$150</td>
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<td>Enhanced - $4/$15/$40/$50/$80/20%/$20%</td>
</tr>
<tr>
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<td>Standard</td>
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<td>30%</td>
<td>$2,500</td>
<td>$6,600</td>
<td>$30/$40/$50/$150</td>
<td>$0</td>
<td>Standard - $6/$25/$50/$80/20%/$20%</td>
</tr>
<tr>
<td></td>
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<td>n/a</td>
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<td>$20/$30/$35/$150</td>
<td>$0</td>
<td>Note: HBL may only be offered at the group's renewal. Group agrees to annual health coach visit.</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
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<td>30%</td>
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<tr>
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<td>HMO Gold $2000</td>
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<td>$6,600</td>
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<tr>
<td><strong>Blue Elect Plus</strong></td>
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<tr>
<td><strong>BCN HSA</strong></td>
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<td>Ded/co-insurance</td>
<td>$4/$15/$40/$50/$80/20%/$20%</td>
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<tr>
<td></td>
<td>HMO Gold $1350/0%</td>
<td>$1,350</td>
<td>0%</td>
<td>n/a</td>
<td>$2,350</td>
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<td>Ded/co-insurance</td>
<td>$10/$30/$50/$80/20%/$20%</td>
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<tr>
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<td>HMO Gold $2700/0%</td>
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<td>Ded/co-insurance</td>
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<td>HMO Silver $3000/0%</td>
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<td>Ded/co-insurance</td>
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<td>30%</td>
<td>n/a</td>
<td>$6,450</td>
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<td>Ded/co-insurance</td>
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</tr>
<tr>
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<td>$1500/0% and $1500/0%</td>
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<td>30%</td>
<td>n/a</td>
<td>$6,450</td>
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</tr>
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<td>HMO Bronze $6350/0%</td>
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<td>$0</td>
<td>Ded/co-insurance</td>
<td>$10/$30/$50/$80/20%/$20%</td>
</tr>
<tr>
<td><strong>Routine Care</strong></td>
<td>HMO Silver $1500</td>
<td>$1,500</td>
<td>30%</td>
<td>n/a</td>
<td>$6,350</td>
<td>$0</td>
<td>Ded</td>
<td>$10/$30/$50/$80/20%/$20%</td>
</tr>
<tr>
<td></td>
<td>HMO Silver $3000</td>
<td>$3,000</td>
<td>20%</td>
<td>n/a</td>
<td>$5,000</td>
<td>$0</td>
<td>Ded</td>
<td>$10/$25/$50/$80/20%/$20%</td>
</tr>
</tbody>
</table>

- Include Elective Abortion Coverage (available with all plans) [ ]
- Are you using HealthEquity to coordinate your HSA? (response required) [ ] Yes [ ] No

*PCP Focus Counties (Employer groups must be located in Bay, Calhoun, Clinton, Eaton, Genesee, Ingham, Kalamazoo, Kent, Livingston, Macomb, Monroe, Muskegon, Oakland, Ottawa, Saginaw, Shiawassee, St. Clair, Van Buren, Washtenaw, and Wayne counties.)*

---

Page 2 of 5, 10012016 BCNC GWC Small Group
4-28 BCN Group Enrollment Agreement January 2017
bcbsm.com
Group Inquiry: 1-800-970-6684

2016 Small Group Menu
Benefit Change (continued)

Group Name (Full Legal Name)  

Group ID  

Sub Group ID  

Class ID  

☐ Stand Alone BCN Advantage Enrollment (do not choose a commercial medical or RX plan, stand alone BCNA requires 5+ enrolling)

### Medicare Options
- ☐ BCN65
- ☐ BCN Advantage

### BCN Advantage (complete for BCN Advantage only)
- ☐ Pkg 2($0/0%/0/$1,000/OV/$20)
- ☐ Pkg 3($0/0%/0/$2,000/OV/$60)
- ☐ Pkg 4($500/10%/1/$1,500/$3,000/OV/$30)

### Medical Plan (Deduct/Coin/ECM/OOPM/OV)
- ☐ None
- ☐ $10/$20
- ☐ $10/$40
- ☐ $15/$50
- ☐ $10/$20/$40
- ☐ $10/$40/$80/20%/20%
- ☐ 20% ($5/$100)

### Drug Plan
- ☐ $15/$50/50% ($370/$100)
- ☐ $15/$50/80/20%/20%
- ☐ $20/90/50% ($380/$100)
- ☐ $20/80/80/20%/20%
- ☐ 20% ($5/$100)

### Blue Vision
- ☐ Add/Change to
- ☐ Delete
- ☐ Maintain
- [ ] Blue Vision
- [ ] Blue Vision Voluntary

#### Blue Vision Voluntary
- 12-12-12, $5/$10
- 12-12-24, $5/$10
- 24-24-24, $5/$10

#### Blue Vision
- 12-12-24, $10/$25
- 12-12-24, $0/$25

### Blue Dental™
- [ ] Add/Change to
- [ ] Delete
- [ ] Maintain

#### Non-Voluntary - PPO (NHPPO)
- PPO Plus 100/80/50
  - $1,000
  - $1,500
- PPO Plus 90/60/50
  - $1,000

#### Voluntary - PPO (NHPPO)
- PPO Plus 100/80/50
  - $1,000
- PPO Plus 80/60/50
  - $1,000

#### Annual Max - PPO (NHPPO)
- $1,200 ($800)
- $1,500 ($800)
- $2,250 ($800)
- $1,000 ($800)

#### Annual Max - PPO (NHPPO)
- $1,250

- ☐ Waive Waiting Period (Proof of prior dental coverage required)
- ☐ [ ] 50% Ortho (Employer Paid - lifetime max matches in-network annual max, voluntary - lifetime max is $1,000, except EPO 100/80/50 is $1,250)

- ☐ Third party pediatric 20%
  - Requires dental coverage attestation.

- Selecting a Voluntary dental plan requires completion of the dental coverage attestation.

The group agrees with the terms as stipulated in this group enrollment and coverage agreement (Parts A, B, C), on the enrollment change of status form, and in the specified Blue Care Network Certificate(s) and rider(s).

By signing this form, I confirm that I understand Blue Care Network will not send hardcopy certificate and riders to subscribers in my group. These documents are available to members at anytime via the member secured services area of the BCN website, MIKen.com. Members may also request a hardcopy by calling Customer Service at 1-800-662-4867.

If you require a hardcopy, send your subscribers hard copies of their certificate and riders, check this box: []

Signature of Group Executive on behalf of the Group and the Group Health Plan: __________________________ Date: ____________

Signature of BCN Rep: __________________________ Date: ____________

Signature of Agent: __________________________ Date: ____________

Signature of Underwriter: __________________________ Date: ____________

Page 3 of 5, 10012016 BCNC GWC Small Group
Complete the applicable sections for all enrolling lines of business

<table>
<thead>
<tr>
<th>Total Group Census</th>
<th>Medical Enrolling</th>
<th>Medical Not Enrolling</th>
<th>Dental Enrollment</th>
<th>Vision Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ineligible - Part Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seasonal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible Employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Note: Enrolling plus Not Enrolling segments equal 'Eligible Employees'. Segments not enrolling (i.e. Union/NHP) captured in the "Not Enrolling" section are still counted towards determining group's rating type.
IMPORTANT NOTICE OF SMALL GROUP REIMBURSEMENT POLICY

The Patient Protection and Affordable Care Act, as amended (PPACA), and related federal and state regulations require BCBSM’s and BCN’s underwritten Small Group Products to be filed and approved with specified Actuarial Values (AV) or “metal levels.” The AV of such products, including those used with an employer-funded health reimbursement arrangement (HRA) or health savings account (HSA), may be impacted if an employer contributes to a Member’s policy, HRA, or HSA an amount that differs from that shown on Part C of the Group Enrollment and Coverage Agreement (Part C). Should an employer do so, BCBSM or BCN may refuse to sell the plan to the employer.

Group may permit employee-funded flexible spending accounts (FSAs) for any plan, provided, however, that Group FSA contributions may not exceed $250 per contract, with the following exceptions: BCBSM’s Healthy Blue Achieve and BCN’s Healthy Blue Living.

Deductibles, co-insurance or copays for non-HSA or non-HRA plans cannot be reimbursed except as specified in Part C.
**Group annual renewal**

**Inventory guidelines**

BCN completes an annual inventory of each group’s membership about six months prior to the group’s annual renewal. This review helps to prevent reimbursement problems, ensures prompt payment of claims and confirms that all the minimum participation requirements have been met.

**How we verify employee eligibility and calculate rates**

If your group has 100 or fewer total enrolled contracts with BCN and BCBSM combined, we’ll send you a BCN Rate Renewal Certification form (see following page for a sample form). You must complete this form and submit it with a Quarterly Wage Detail Report within 21 days of its receipt.

The information on the Rate Renewal Certification form and the Quarterly Wage Detail Report helps us verify employee eligibility and determine your rates. The Quarterly Wage Detail Report should be the most recent one you have filed with the State of Michigan.

To ensure your group’s confidentiality, we accept only mailed forms. If you miss the filing deadline, you risk being placed in a higher rating category and receiving a higher rate than is appropriate for you.

Groups that do not file Quarterly Wage Detail Reports should provide a copy of their Payroll Summary along with a signed letter on company stationery stating that they do not file Quarterly Wage Detail Reports. Call the Rate Renewal Customer Service Center at 1-866-345-7974 for more information.
Group annual renewal (continued)

Rate Renewal Certification

Return to:

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Customer Name: ____________________________
Agent Name: ________________________________

Agent ID: ___________________ Distribution Code: ___________________
Renewal Year: ___ / Month: ___

RETURN THIS FORM ALONG WITH YOUR MOST RECENT COMPLETED QUARTERLY WAGE DETAIL REPORT IN THE ENCLOSED POSTAGE PAID ENVELOPE.

1. Provide the number of full time employee equivalents based on the definition on the back of the form.

2. Provide the number of eligible employees based on the eligibility definition from the back.
   Number of eligible employees in Michigan: ___
   Number of eligible employees outside of Michigan: ___

3. List all health carriers that are offered to your employees, including the number of medical contracts enrolled in each.

<table>
<thead>
<tr>
<th>Carrier 1</th>
<th>Carrier 2</th>
<th>Carrier 3</th>
<th>Carrier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE CROSS BLUE SHIELD M I</td>
<td>BLUE CARE NETWORK M I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of BCN retirees enrolled: ___</td>
<td>BCN retirees enrolled: ___</td>
<td>BCN COBRA enrolled: ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of employees enrolled: ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you have a collective bargaining agreement? [ ] Yes [ ] No
   If yes, please complete the following:
   Union Name: ____________________________
   Carrier from question 2 above: ___
   Carrier from question 2 above: ___
   Number of employees enrolled: ___
   Number of employees enrolled: ___

5. Identify the number of employees NOT seeking or offered medical coverage through your health plan.
   Number of eligible employees covering NO form of coverage or not offered coverage: ___
   Number of eligible employees covered by a spouse, another employer or prior retirement plan: ___

Signature of Group Executive: ____________________________
Title: ____________________________
Date: ____________________________

Read the reverse side of this certification form before answering the above questions.
Group annual renewal (continued)

For each employee listed, include on your Quarterly Wage Detail Report the following designation for their status:

- FT = Full Time
- PT = Part Time
- NH = New Hire
- R = Retiree
- SEAS = Seasonal
- TERM = Terminated
- C = COBRA
- OWN = Owner

How to check your totals on the form:
- Add the 6 boxes marked A-F
- Add the 2 boxes marked G & H
- These two totals should equal each other

RATE RENEWAL CERTIFICATION INFORMATION AND DEFINITIONS

Full-time employee equivalent is defined as all employees who work an average of 30 hours a week including provided hours for part-time and seasonal employees during the preceding calendar year. Calculate the number of full-time equivalent employees for each month using the 120-hour per month method. Find the sum of the number of full-time equivalent employees and full-time equivalent employees for each month in the year and divide by 12 to obtain the full-time equivalent count.

Eligible employees are defined as full-time employees with a normal workweek of 30 or more hours. As a part of the total number of eligible employees, you may choose to include those working 17.5 to 30 hours as long as the eligibility criterion is applied uniformly without regard to health status-related factors.

The numbers proceeding the definitions below correspond to the line numbers on the form where the term is used.

1. Full-Time Employee Equivalent
   This is the result of the full-time employee equivalent calculation above.

2. Eligible employees in Michigan
   These are employees working at a location within Michigan.

3. Eligible employees outside of Michigan
   These are employees working in a state other than Michigan.

4. Medical contracts
   "Medical contracts" are those that cover hospital and physician claims and should be counted as enrolled actives, COBRA or retiree. Plans covering ONLY dental, should count the dental contracts.

5. Actives enrolled
   "Actives enrolled" are full-time employees with medical coverage (they must meet the definition of "eligible employee" above).

6. Enrolled retirees
   These are persons previously employed by your company, who are now retired and have retained their company-sponsored health insurance benefits.

7. Enrolled COBRA
   These are former employees retaining company health insurance benefits through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

8. Collective bargaining agreement
   This is an agreement between a union and an employer that specifies such items as wages, hours and benefits including health insurance.

9. Employees not seeking or offered coverage
   This group is composed of employees who are not enrolled in any group-sponsored health plan, or who choose to waive the offered coverage.

10. Employees with other coverage
    These are employees who may not be enrolled because they have coverage through a spouse, through another employer or through a prior retirement plan.

Please return the form along with your most recent completed Quarterly Wage Detail Report in the enclosed postage paid envelope.
Renewal Package

We’ll send you a renewal package

The renewal package you receive is customized to your group and your group’s size.

Each package will include a letter explaining how health reform is affecting benefit development and a Benefit and Rate Schedule. All small and some large groups will also receive a Rate Renewal Change document. The next few pages will show samples of these rate documents.
## Rate Renewal Change

**CID:** 279571  
**Group subgroup class:** 00279571-0001-0001

**Rate Effective:** 01/01/2014

**Managing Agent:** 01_Grotenhuis  
**Agent:** 13632  
**Endorsed by:** Not Applicable

### Current Premium

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Current Monthly Premium (includes Taxes and Fees)</td>
<td>$3,563.98</td>
</tr>
<tr>
<td>Total Annual Premium</td>
<td>$42,766.32</td>
</tr>
</tbody>
</table>

### Renewal Compliant Benefit Premium

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Billable Members</td>
<td>12</td>
</tr>
<tr>
<td>Total Renewal Monthly Premium (includes Taxes and Fees)</td>
<td>$5,017.34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Annual Premium without Taxes and Fees</td>
<td>$58,067.20</td>
</tr>
<tr>
<td>Estimated Annual Taxes and Fees Assessment</td>
<td>$2,140.09</td>
</tr>
<tr>
<td>Total Annual Premium</td>
<td>$60,208.08</td>
</tr>
</tbody>
</table>

### Projected Change in Monthly Premium

40.78%

---

1. Renewal premium are based on enrollment at the time of renewal development.

The figures above include certain federal taxes and fees enacted by the Patient Protection & Affordable Care Act as well as certain State taxes and assessments. The figures are estimates and may change in future billings; they do not include other taxes or assessment that the Federal government or States may impose with respect to medical services or claims and that may be included in future bills.

Reference number: NA

Blue Cross Blue Shield of Michigan and Blue Care Network reserve the right to adjust rates if any of the assumptions or calculations used to develop the rates are incorrect.
### BENEFIT AND RATE SCHEDULE

Rate Effective: 01/2014  
Renewal Month: January

<table>
<thead>
<tr>
<th>Customer ID:</th>
<th>279571</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group-subgroup-class:</td>
<td>0037957-0001-0001</td>
</tr>
<tr>
<td>Endorsed By:</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Rating Type:</td>
<td>Small Group (Return)</td>
</tr>
<tr>
<td>Cluster Code:</td>
<td>FAC</td>
</tr>
<tr>
<td>County:</td>
<td>Wayne</td>
</tr>
</tbody>
</table>

#### CERTIFICATES

| CERT | CL55SM |
| CERT | SG BDEPO 10/0/20 (09/20/20) Vol |
| CERT | SG Blue Vision Vol 12-13-14 $10/25 |

#### MEDICAL RIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1000</td>
<td>$1,000 Deductible</td>
<td>$1,000</td>
</tr>
<tr>
<td>C30%</td>
<td>30% Co-insurance</td>
<td></td>
</tr>
<tr>
<td>300PM</td>
<td>$300 Out of Pocket Maximum</td>
<td>$300</td>
</tr>
<tr>
<td>C020</td>
<td>$20 Office Visit Copay</td>
<td></td>
</tr>
<tr>
<td>40RP</td>
<td>$40 Specialist Visit Copay</td>
<td></td>
</tr>
<tr>
<td>UR50</td>
<td>$50 Urgent Care Visit Copay</td>
<td></td>
</tr>
<tr>
<td>ER100</td>
<td>$100 Emergency Room Visit Copay</td>
<td>$100</td>
</tr>
<tr>
<td>IM100</td>
<td>$100 Diagnosing Imaging Copay</td>
<td></td>
</tr>
<tr>
<td>DS5%</td>
<td>5% Co-insurance on Diabetic Supplies</td>
<td>$500</td>
</tr>
<tr>
<td>WR/OV</td>
<td>Waivers Deductible for Specialist Visits</td>
<td>$500</td>
</tr>
<tr>
<td>VACV2</td>
<td>Voluntary Abortions Covered at 50%</td>
<td>$500</td>
</tr>
<tr>
<td>FOCUS</td>
<td>Narrow Network Rider</td>
<td></td>
</tr>
</tbody>
</table>

#### DRUG RIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>P415GS</td>
<td>M3000 M3X</td>
<td>Rx: $4/5/15/540/600/250 MOP3X (Med OPMP applies)</td>
</tr>
</tbody>
</table>

#### DENTAL RIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BD-PPG</td>
<td>RIDER BD PPG V SG - PLAN D2</td>
<td></td>
</tr>
<tr>
<td>BD-RCS</td>
<td>RIDER BD RCS - SG BLUE DENTAL BENEFITS FREQUENCY</td>
<td>$500</td>
</tr>
<tr>
<td>BDWP0/120</td>
<td>RIDER BDWP0/120 SG BLUE DENTAL - WAITING PERIOD</td>
<td>$500</td>
</tr>
</tbody>
</table>

#### VISION RIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BVC</td>
<td>RIDER BVC $10/35 SG BLUE VISION CO-PAYMENT REQUIREMENT</td>
<td>$10/35</td>
</tr>
<tr>
<td>BVFLL</td>
<td>RIDER BVFLL-00 BLUE VISION FREQUENCY LIMIT FOR LENSES</td>
<td>$500</td>
</tr>
</tbody>
</table>

Reference Number: NA

All Benefit Descriptions may not be applicable to all subscribers.
### Premium payments

**Payment due dates**

BCN health care coverage is only offered on a prepaid basis. All premiums must be paid in full, 30 days in advance of the coverage effective date.

**Automatic payment option**

Groups can elect to pay premiums through our autopay program. There is no charge for the service that offers payment convenience and eliminates the possibility of delinquent payment.

The premium deducted is the amount due based on the number of enrollees BCN has on record for the group at the time the invoice is generated. We send the group a monthly statement showing the amount we deducted.

To enroll, complete the form on the next page or download a form available at [bcbsm.com](http://bcbsm.com). Through the form, the group authorizes BCN to deduct payments from a designated checking or savings account on the date the group’s premium payment is due.
# Group Authorization Agreement for Automatic Payments

<table>
<thead>
<tr>
<th>Group name:</th>
<th>Group decision maker:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BCN group ID:</th>
<th>Subgroup ID:</th>
<th>Street address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip code:</th>
<th>Telephone number:</th>
</tr>
</thead>
</table>

## Authorization for automatic payments

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my group’s checking/savings account amounts necessary to pay the premium owed by my group under my group’s BCN contract. This authority will remain in effect until I, or another group representative, notifies you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

<table>
<thead>
<tr>
<th>Bank name:</th>
<th>Branch:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip code:</th>
</tr>
</thead>
</table>

Please deduct my monthly BCN premium from (check one):

- [ ] Checking account (Please include a voided check when you return this form.)
- [ ] Savings account (Please include a voided deposit slip when you return this form.)

If you bank online, please write in your checking or savings account number and bank routing number:

- Account number _______________________
- Bank routing number ___________________

Signature of group decision maker: __________________________ Date: ________

Requests received by the 5th of the month will take effect the following month. Withdrawals will occur each month on the date your premium payment is due. We will send you written notification of the date your automatic payments begin. Please fax, email or mail the completed form to:

- Fax: 1-888-615-8793
- Email: bcnaccountsreceivable@bcbsm.com
- Mail: Blue Care Network
  Collections - Mail Code C415
  P.O. Box 5043
  Southfield, MI 48086-5043

## Blue Care Network use only

<table>
<thead>
<tr>
<th>Processor:</th>
<th>Process date:</th>
<th>Effective date:</th>
</tr>
</thead>
</table>

CF 10542 MAY 11
## Delinquencies

**Delinquency defined**  
Your group is considered delinquent when BCN has not received the required payment by the billing due date.

**Nonpayment of premiums**  
If BCN has not received the required payment by the billing due date, we send a delinquency notice to your group. If BCN doesn’t receive premiums by the requested date on the delinquency notice, we will send you a final cancellation notice.

If your group’s premiums are more than 30 days past due, BCN may immediately terminate coverage retroactive to the date through which premiums were paid in full. Your group will not be eligible for re-enrollment for one year following the date of cancellation.

**Returned checks (NSF)**  
If a check received in payment for a premium is returned from the bank marked nonsufficient funds, the check must be replaced with certified funds within 10 days or the group will be cancelled.

If the group submits another check within six months that is returned for nonsufficient funds, the group will be cancelled. The group cannot be reinstated for one year.

If a group is more than one month delinquent in submitting a premium payment and the check submitted for that payment is returned from the bank marked nonsufficient funds, the group will be cancelled. The group cannot be reinstated for one year.
**Group coverage cancellation**

**Cancellation conditions**
The table below outlines the conditions for cancellation of group coverage.

<table>
<thead>
<tr>
<th>Initiated By</th>
<th>Cancellation Occurs</th>
<th>Coverage Ends</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>On monthly cycle date with 30 calendar days advance written notice to BCN</td>
<td>On date requested (if 30 calendar days advance notice has been provided to BCN)</td>
<td>No COBRA or extension of benefits available</td>
</tr>
<tr>
<td>BCN (participation requirements not met)</td>
<td>On monthly cycle date</td>
<td>On date specified by BCN (with 30 calendar days notice)</td>
<td>Individual coverage available</td>
</tr>
<tr>
<td>BCN (group eligibility requirements not met)</td>
<td>On monthly cycle date</td>
<td>On date specified by BCN (with 30 calendar days advance notice)</td>
<td>Individual coverage available</td>
</tr>
<tr>
<td>BCN (substandard enrollment)</td>
<td>On monthly cycle date</td>
<td>On date specified by BCN (with 30 calendar days advance notice)</td>
<td>Individual coverage available</td>
</tr>
<tr>
<td>BCN (due to group’s nonpayment)</td>
<td>When payment is overdue</td>
<td>On group’s paid-through date</td>
<td>• Individual coverage available</td>
</tr>
<tr>
<td></td>
<td>Note: Group may apply for re-enrollment within one year of cancellation date by BCN</td>
<td></td>
<td>• Cost of services or benefits provided to members during the default period will be charged to members</td>
</tr>
<tr>
<td>BCN (Medicare eligibility for one-subscriber group)</td>
<td>On monthly cycle date</td>
<td>On date specified by BCN (with 30 calendar days advance notice)</td>
<td>Member should apply for BCN Medicare nongroup coverage</td>
</tr>
</tbody>
</table>
**Group eligibility**

**Defining a group plan**
An employee welfare benefit plan is one that an employer or an employee organization (such as a union) establishes to provide medical care to employees and their dependents. Employers can be:

- Small: employing from 1 to 50 eligible employees
- Large: employing at least 51 eligible employees

**Eligible employers**
To be eligible as an employer, the group must be:

- Located in Michigan
- Have a single taxpayer identification number.
- Have an employee relationship with participants in the group health plan, categorized by
  - Withholding payroll taxes on wages paid to employees
  - Contributing to the Michigan Unemployment Insurance Trust Fund for employees
  - Providing Workers’ Compensation for workers

**Eligible employees**
An eligible employee is one who:

- Works full-time with a normal work week of 17.5 to 30 hours
- Performs services that the employer controls in terms of what to do and how to do it
- Is subject to discharge by the employer
Subscriber eligibility

<table>
<thead>
<tr>
<th>Eligible Employees</th>
<th>Eligibility Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers/Owners</td>
<td>• Have a direct and active interest in the group</td>
</tr>
<tr>
<td></td>
<td>• Receive a major source of their earned income from the group</td>
</tr>
<tr>
<td></td>
<td>• Physically report to the place of business at least once a week</td>
</tr>
<tr>
<td></td>
<td>• Have a direct voice in all major decisions</td>
</tr>
<tr>
<td></td>
<td>• Live in the BCN service area a minimum of nine months of the year</td>
</tr>
<tr>
<td>Full-time workers</td>
<td>Must be an eligible employee who works full-time: a normal work week of 30 or more hours.</td>
</tr>
<tr>
<td>Part-time workers</td>
<td>Must work 17.5 to 30 hours per week, as specified in the Group Enrollment and Coverage Agreement.</td>
</tr>
<tr>
<td>Retirees</td>
<td>Participate only if the group has an established retiree segment with a documented retirement benefit program. Note: The group can establish a retiree segment if there is a corresponding active segment that meets Blue Care Network participation requirements. Individuals who retire must be transferred to the retiree segment when they begin receiving pension benefits from the group. Retirees may or may not be eligible for Medicare at the time of retirement, and their eligibility for Medicare will determine the type of coverage they receive.</td>
</tr>
<tr>
<td>Seasonal employees</td>
<td>Regularly works each year at the same time and for the same length of time (less than a year). Seasonal employees are eligible for enrollment in the health plan if the employer’s business is affected by the season of the year (tourism, crop growing, holiday) and employment is at least nine months of the year</td>
</tr>
</tbody>
</table>
**Enrollment Guidelines**

<table>
<thead>
<tr>
<th><strong>Effective date of coverage</strong></th>
<th>The effective date of coverage for individuals who signed up during initial enrollment is the date specified in Part B of your Group Enrollment and Coverage Agreement.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New hires</strong></td>
<td>Eligible new hires may enroll for coverage for themselves and their eligible dependents according to the provisions of your Group Enrollment and Coverage Agreement. If your health care plan contains a new hire-wait period, coverage will begin following this period. The new hire-wait period cannot exceed 90 days.</td>
</tr>
<tr>
<td><strong>Rehires</strong></td>
<td>Individuals who are rehired or who return to work after a layoff or leave of absence may be readmitted to coverage based on your rehire wait period as stated in Part B of the Group Enrollment and Coverage Agreement. The rehire wait period cannot exceed 90 days.</td>
</tr>
<tr>
<td><strong>Transfers from Blue to Blue</strong></td>
<td>Individuals who were covered by a Blue Cross Blue Shield of Michigan or BCN plan through another employer may transfer into your Blue Cross plan when they are hired. The effective date of coverage must be the date of hire. Depending on your personnel policy, you may allow coverage immediately or following a new hire-wait period.</td>
</tr>
</tbody>
</table>
**Enrollment Guidelines (continued)**

### Transfers from other carriers

**Loss of coverage**

New hires and their eligible dependents who were covered by another carrier through a spouse may request a transfer to your plan after the new hire-wait period if they lost their coverage. Application must be made within 31 days of the loss of coverage or be delayed until your next open enrollment. Coverage is effective on the date coverage is lost. A letter from the previous health insurance carrier or other group verifying loss of eligibility for coverage is required.

**Other reasons**

New hires who elect to change carriers may transfer only during an open enrollment period.

### Veterans

An employee returning from military service and his or her covered dependents are entitled to immediate reinstatement of health coverage — provided that the service in uniform does not exceed five years. The health plan may not impose a wait period or exclude preexisting conditions — except for illnesses and injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the military.

To qualify for reinstatement of coverage, BCN requires that the member:

- Must have been covered under a BCN contract immediately prior to being called to active duty
- Must reapply for employment within 90 days of discharge. Note: Coverage will be effective as of the date of re-employment
- Include proof of discharge with the application
Dependent eligibility

Defining dependents

Eligible dependents of individuals with BCN coverage include:
- Spouse
- Dependent children
- Principally supported children
- Disabled children (over 26 years of age)
- Surviving spouse or dependent (if this rider is offered)
- Domestic partners (if this rider is offered)

Dependent eligibility

Eligibility for dependents is defined in the chart on the following page.
### Dependent eligibility (continued)

<table>
<thead>
<tr>
<th>Eligible Dependents</th>
<th>Eligibility Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse</strong></td>
<td>The legally married husband or wife of the subscriber.</td>
</tr>
<tr>
<td><strong>Dependent children</strong></td>
<td>Children of the subscriber or subscriber’s spouse by birth, marriage, legal adoption or legal guardianship who are under 26 years of age.</td>
</tr>
<tr>
<td><strong>Newborn</strong></td>
<td>Newborns are automatically covered for the first 31 days of life. To continue coverage for the newborn, an enrollment request must be submitted to BCN within 31 days of the newborn’s birth.</td>
</tr>
</tbody>
</table>
| **Principally supported children** | Children related to the subscriber by blood or marriage who:  
- Are under 26 years of age  
- Are unmarried  
- Have legal residence with the subscriber  
- Are claimed as dependents on the subscriber’s most recent federal income tax return or qualify in the current tax year for dependency tax status  
- Are dependent on the subscriber for principal support in accordance with Internal Revenue Service standards and have met these standards for at least six months prior to applying for coverage (coverage begins three months after the subscriber’s application)  
- Are not eligible for Medicare |
| **Disabled children (Michigan Insurance Code 500.2264)** | Disabled unmarried dependent children may remain on the subscriber’s contract beyond the end of the calendar year in which they turn 26, provided the child is:  
- Diagnosed as totally and permanently disabled due to a physical or developmental condition  
- Incapable of self-support due to the physical or developmental disability, as verified by a physician*  
- Dependent on the subscriber for support and maintenance  
- Resides in a BCN service area  
*Note: Physician certification, verifying the child’s physical or developmental disability, must be submitted to BCN no later than 31 days after the end of the calendar year in which the child turns age 26 |
| **Spouse or dependent due to survivorship clause** | A surviving spouse or dependent is eligible if the group offers a survivorship clause and the subscriber elects it before or at retirement. A surviving spouse or dependent must live in the BCN service area a minimum of nine months of the year.
# Exclusions

**Ineligible workers**  
The following categories of employees are not eligible for BCN health care coverage:

- Temporary workers, students in training, co-ops and foreign exchange students
- Independent contractors and commissioned personnel
**Documents required for dependent eligibility verification**

**Eligibility documents**

To ensure that you are only paying premiums for eligible dependents, we may request documentation to verify the eligibility of dependents. These are as follows:

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Required Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>• Enrollment/Change of Status form*</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>• Enrollment/Change of Status form*</td>
</tr>
<tr>
<td>Child adopted or guardianship by subscriber</td>
<td>• Enrollment/Change of Status form*</td>
</tr>
<tr>
<td></td>
<td>• Court order or documentation verifying legal guardianship, or intent to adopt, or petition for guardianship</td>
</tr>
<tr>
<td>Principally supported child (after nine months of support)</td>
<td>• Enrollment/Change of Status form*</td>
</tr>
<tr>
<td></td>
<td>• Notarized statement or tax return verifying support</td>
</tr>
</tbody>
</table>

*Always required. To view this form, see Section 6.*

**Complying with document requests**

Always submit supporting documentation with the Enrollment/Change of Status form. If we ask for additional documentation, you have only 10 days to comply.

If BCN does not receive documentation to verify the dependent’s eligibility, the dependent will not be added. The subscriber will have to wait until the next open enrollment period to add the dependent.

**Enrollment/Change of Status**

Members should submit an Enrollment/Change of Status form for themselves or their dependents within 31 calendar days of a qualifying event (date subscriber or member became eligible for enrollment into the group). This will allow BCN time to process the form and request additional documentation as required.
## Sponsored dependent continuation coverage

### Sponsored dependent coverage defined
A sponsored dependent is any adult dependent over 25 (or the age specified by the Group Enrollment and Coverage Agreement) who is a family member of the subscriber.

Coverage effective dates are one of the following:
- Initial enrollment of the subscriber
- First of the month in which qualifying event occurs
- Annual open enrollment effective date

Sponsored dependent coverage applies only to groups of 51 or more eligible subscribers that have selected the Sponsored Dependent rider.

There is an added premium for this coverage.

### Sponsored dependent eligibility guidelines
A dependent is eligible for continuation coverage if he or she:
- Is over 19 years of age
- Is not eligible for coverage as a dependent child
- Is related to the subscriber by blood, marriage, or legal adoption within the terms of the Internal Revenue Code for dependents
- Qualified as a dependent on the subscriber’s last federal tax return filed under the Internal Revenue Code
- Receives more than half of his or her support from the subscriber
- Resides in the subscriber’s household
- Is ineligible for or not enrolled in Medicare or Medicaid

### Form requirements
The following documentation must be filed with BCN:
- Enrollment/Change of Status form (See Section 6 for more about the Enrollment/Change of Status form.)
- Subscriber’s most recent tax return
**Domestic partner coverage**

**Domestic Partner – Same Gender Rider**

Effective 04/01/16, groups may no longer add the same gender domestic partner rider (DPR) to their coverage. If your organization’s coverage currently includes the same gender domestic partner rider, you may continue to add new domestic partners and their eligible dependent children until the 2017 renewal date for small groups, or until Dec. 1, 2017, for large groups, unless your group has already eliminated domestic partner coverage at its renewal.

- Domestic partners under rider DPR are persons of the same gender who permanently reside together as each other’s sole domestic partner.

- Coverage for a subscriber’s same gender domestic partner and dependent children of the partner is available to group customers only when the same gender domestic partner rider is included in their coverage.

Note: Opposite sex domestic partners are not eligible for coverage under the domestic partner same gender rider.

Blue Care Network will close the DPR rider for same-gender domestic partners by the end of December 2017. For groups that want to continue coverage, the DRPCOS rider for same- and opposite-gender, domestic-partners is available and can be added now or at your group’s 2017 renewal.

**Domestic Partner – Same and Opposite Gender Rider**

Domestic partners under rider DRPCOS are persons of the same or opposite gender who permanently reside together as each other’s sole domestic partner.

Coverage for a subscriber’s domestic partner and dependent children of the partner is available to group customers only when the DRPCOS rider is included in their coverage.
### Domestic partner coverage (continued)

**Domestic Partner Eligibility Requirements**

The following eligibility requirements apply to domestic partners and their eligible dependents enrolled under Rider DPRCOS (same and opposite gender partners):

- The domestic partners are 18 years of age or older.
- Neither domestic partner is legally married.
- The domestic partners are not related by blood in a manner that would prohibit legal marriage.
- The domestic partners have lived together for the past 12 consecutive months. The subscriber must provide your organization proof that the subscriber and domestic partner have lived together for this period of time. Proof may be established by a driver’s license, voter registration, student identification, city or county registration, rental or mortgage agreement or other specific documentation.
- The subscriber has provided you with a signed and notarized Affidavit of Domestic Partnership.
- The subscriber submits to you a completed Change of Status form located in the Enrollment Change of Status document to add a domestic partner.

Your organization will review these documents and determine if the domestic partner is eligible for coverage. Your organization is required to retain copies of the signed and notarized Affidavit, Enrollment Change of Status document and a record of the date the application was approved.

BCN reserves the right to request copies of the above documentation including proof of residency. Please see the DPRCOS rider for complete requirements.
Domestic partner coverage (continued)

<table>
<thead>
<tr>
<th>Domestic Partner Coverage Effective Date</th>
</tr>
</thead>
</table>

Coverage for a domestic partner may not take effect until 90 days after the application has been approved by your organization. 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, 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.

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.
Domestic partner coverage (continued)

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.
Continuing Coverage — COBRA

When members leave the group

Subscribers or dependents who leave your group or are no longer eligible for benefits can purchase their own BCN benefits without a lapse in coverage. They may qualify for COBRA:

- COBRA (Consolidated Omnibus Budget Reconciliation Act) extends coverage through your plan for a specified length of time, provided you have 20 or more full- or part-time employees.

The member can choose coverage through COBRA for the length of time determined by his or her particular situation.

About COBRA

This explanation is not intended to replace the group’s need to consult its own counsel.

The Consolidated Omnibus Budget Reconciliation Act is a federally mandated, employer-sponsored and administered health care plan for covered employees and dependents who lose their group health insurance. COBRA applies only to employer groups with 20 or more employees (except for church plans defined in Section 414(e) of the Internal Revenue Code and government employers who have similar rules under a different law).

COBRA allows the “qualified beneficiary” (the eligible person) to continue coverage through your group plan for a specific length of time. You continue to administer the coverage, but the qualified beneficiary or others connected to the qualified beneficiary pay you directly for the cost of the coverage.

For more information on COBRA administration, call 202-219-8776.

Or write:

Division of Technical Assistance and Inquiries — Room N-5625
The U.S. Department of Labor, Pension and Welfare Benefits
200 Constitution Ave. NW
Washington, D.C. 20210
**Continuing Coverage — COBRA (continued)**

**Who qualifies for COBRA**

Anyone covered under your organization’s plan the day before a COBRA qualifying event is eligible for COBRA and is called a qualified beneficiary.

A COBRA qualifying event could include but is not limited to:

- Employment termination
- Divorce
- Layoff
- Reduction in hours
- Dependents who lose eligibility

---

**For information**

Call BCN Customer Service at 1-800-662-6667 for more information about COBRA or other BCN individual products.
Frequently asked questions about COBRA coverage

When group coverage ends, what health care coverage is available? How is it activated?

- Groups with 20 or more full- or part-time employees must offer COBRA. (Groups exempt from the requirement: churches defined in Section 414(e) of the IRS code and government employers who have similar rules under a different law.)
- The group must notify all members in writing about their specific COBRA rights within 14 calendar days of the date of the qualifying event, or the date the group learned of the event from the subscriber.
- The qualified beneficiary or his or her representative must sign up within 60-calendar days from the date of notification.

How long can a subscriber or eligible dependent keep the coverage?

COBRA eligibility ends:

- When the qualified beneficiary reaches the allowed time limit:
- 18 months from when the employee or eligible dependents lose coverage due to termination or reduction of work hours
- 29 months from when employees who are disabled stopped working; the disability can have occurred within 60 days of their stopping work. Subscriber must provide a Certificate of Disability from the Social Security Administration during the initial 18-month COBRA period or within 60 calendar days of receiving the certificate
- 36 months for eligible dependents from the date the subscriber dies, is legally divorced or separated, or when a dependent becomes ineligible for coverage
- Your group stops offering any group health BCN plan.
- The qualified beneficiary or representative does not make premium payments.
- The qualified beneficiary becomes covered under another health plan without limits for pre-existing conditions or becomes entitled to Part A or Part B Medicare benefits.
## FAQs about COBRA coverage (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much does coverage cost?</td>
<td>Groups with 20 or more full- or part-time employees must COBRA coverage costs the same as the group premium rate for months 0-18. The group can include an additional 2 percent administration fee.</td>
</tr>
<tr>
<td>How are premiums paid?</td>
<td>The group collects and submits premiums to BCN. Enrollees, or their representatives, must pay any retroactive premiums and current premiums within 45 calendar days from date of COBRA election.</td>
</tr>
</tbody>
</table>
| How do individuals sign up for coverage?                | - Tell BCN of subscriber termination by submitting Enrollment/Change of Status form to BCN within 31 calendar days of termination date.  
- Individual election must take place within 60 calendar days of their being notified of their group coverage ending.  
- Group forwards application to BCN within 31 calendar days of election.  
- The COBRA effective date must be the day following the termination date. There can be no lapse in coverage. |
| Does the subscriber keep the same BCN benefits?         | Yes.                                                                                                                                 |


**Uniformed Services Employment and Reemployment Rights Act**

**USERRA explained**

USERRA requires group health plans to offer up to 24 months of continuation coverage to persons absent from employment due to military service. USERRA applies to all employers, including groups with fewer than 20 employees who are not subject to COBRA.

USERRA runs concurrent with COBRA.

The employer may charge up to 102 percent of the full premium cost for continuation coverage unless the employee is called to active duty for fewer than 31 days; those individuals are only required to pay the applicable employee share of the premium.
Eligibility audits

**Member audits**

BCN periodically conducts membership audits to ensure accuracy. The group is responsible for reviewing the audit reports received from BCN and reporting discrepancies immediately to BCN.

The table below describes the types of audits BCN conducts.

<table>
<thead>
<tr>
<th>Audit Type</th>
<th>When</th>
<th>Members</th>
<th>BCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>COBRA</td>
<td>Monthly</td>
<td>COBRA members exhausting eligibility period</td>
<td>• Notifies member by mail when COBRA will be exhausted and gives member their options for continued coverage</td>
</tr>
<tr>
<td>TEFRA (Tax Equity Fiscal Responsibility Act) working aged</td>
<td>Every year (Spring)</td>
<td>Members over age 65 with active coverage</td>
<td>• Sends surveys to members over 65 to determine whether Medicare status has changed.</td>
</tr>
<tr>
<td>Medicare*</td>
<td>Monthly</td>
<td>✓ Members who are nearing age 65: ✓ Retirees ✓ Dependents</td>
<td>• Sends surveys to members four months prior to their 65th birthday to determine Medicare status</td>
</tr>
</tbody>
</table>

*Contact Blues sales representative or agent to establish formal retiree classification or to cancel coverage.
**Membership Collection System (eMCS)**

<table>
<thead>
<tr>
<th>Submit membership data electronically</th>
<th>We offer a Web-based membership collection system to help groups and agents manage their Blues coverage. eMCS is available at no charge to groups with 10 or more members and requires very few system or programming changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How eMCS works</td>
<td>Users log in to the secured Web portal through their personal computer. You designate authorized users for your group and receive specific logon and password identification.</td>
</tr>
</tbody>
</table>
| Control over membership records     | eMCS offers these advantages:  
   - Less paperwork  
   - Instant information on your membership  
   - More control over your membership records |
| To enroll                           | Visit us on the web at [bcbsm.com](http://bcbsm.com). Select I am an Employer and then log in to register your Blue Care Network group with eMCS. |
# Medicare Coverage

## About Medicare

Medicare is a federal health insurance program for individuals age 65 and older, certain disabled people and those with end stage renal disease. The Centers for Medicare and Medicaid Services, not BCN, determines eligibility (entitlement) for Medicare coverage.

See Section 10 of this manual for detailed information about Medicare coverage.

## Medicare eligibility

The Medicare Secondary Payer law defines when Medicare will be the primary payer for services covered under a group health plan. According to the law, a group may not offer Medicare complementary coverage to an individual who is eligible for group health coverage and should only have Medicare as the secondary carrier.

See the chart on the following page for how the Medicare Secondary Payer law defines eligibility.
<table>
<thead>
<tr>
<th>If Subscriber...</th>
<th>AND/OR...If Dependent...</th>
<th>IF Group has under 20 full time/part time and seasonal employees...</th>
<th>IF Group has 20 to 59 full time/part time and seasonal employees...</th>
<th>IF group has 100+ full time/part time and seasonal employees...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age 65 or over, still working and has Medicare Parts A and B</td>
<td>Is age 65 or over and has Medicare Parts A and B</td>
<td>New or Existing Member(s) May enroll in a Medicare primary plan (not to be confused with a retiree class) until Subscriber retires.</td>
<td>New or Existing Member(s) Subscriber and spouse in BCN plan.</td>
<td>New or Existing Member(s) Subscriber and spouse in BCN plan.</td>
</tr>
<tr>
<td>Is age 65 or over, still working and does not have Medicare Part B</td>
<td>Is age 65 or over</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
</tr>
<tr>
<td>Is age 65 or over, retired and group does not have a retiree segment</td>
<td></td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
</tr>
<tr>
<td>Is age 65 or over, retired and group has a retiree segment</td>
<td></td>
<td>New or Existing Member(s) Medicare Primary Member must have Medicare Part A&amp;B. Member(s) will be placed in a Retiree Class.</td>
<td>New or Existing Member(s) Medicare Primary Member must have Medicare Part A&amp;B. Member(s) will be placed in a Retiree Class.</td>
<td>New or Existing Member(s) Medicare Primary Member must have Medicare Part A&amp;B. Member(s) will be placed in a Retiree Class.</td>
</tr>
<tr>
<td>Is age 65 or over, not actively working and does not have Medicare Part B</td>
<td></td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
</tr>
<tr>
<td>Is age 65 or over, not actively working and does not have Medicare Part A</td>
<td></td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
</tr>
<tr>
<td>Is age 65 or over, not actively working and has Medicare Parts A and B</td>
<td>Is age 65 or over and does not have Medicare Part B</td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
</tr>
<tr>
<td>Is under age 65 and working</td>
<td></td>
<td>New Member(s) NOT Eligible Existing Member(s) Coverage terminated.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
<td>New or Existing Member(s) BCN Primary Subscriber and spouse in BCN plan.</td>
</tr>
<tr>
<td>Is under age 65, retired and covered under retiree segment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is under age 65, retired and covered under retiree segment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

bcbsm.com
Group Inquiry: 1-800-970-6684
### Medicare Eligibility/Enrollment Grid — Page 2

<table>
<thead>
<tr>
<th>If Subscriber ...</th>
<th>AND/OR...If Dependent...</th>
<th>IF Group has under 20 full time/part time employees...</th>
<th>IF Group has 20 to 59 full time/part time employees...</th>
<th>IF group has 100+ full time/part time and seasonal employees...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is under age 65, still working and disabled (as specified by Social Security guidelines)</td>
<td>Is under age 65 and disabled (as specified by Social Security guidelines)</td>
<td>New or Existing Member(s) Medicare Primary. Member(s) must have Medicare Parts A and B.</td>
<td>New or Existing Member(s) Medicare Primary. Member(s) must have Medicare Parts A and B.</td>
<td>New or Existing Member(s) BCN primary. Member(s) has BCN plan.</td>
</tr>
<tr>
<td>Is under age 65, disabled (as specified by Social Security guidelines) and not currently employed (as specified by 1993 COBRA guidelines.)</td>
<td>Is under age 65 and disabled (as specified by Social Security guidelines) and not currently employed (as specified by 1993 COBRA guidelines.)</td>
<td>New or Existing Member(s) Medicare Primary. BCN NOT available. Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.</td>
<td>New or Existing Member(s) Medicare Primary. BCN NOT available. Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.</td>
<td>New or Existing Member(s) Medicare Primary. BCN NOT available. Member(s) must have Medicare Parts A and B to enroll in BCN nongroup coverage.</td>
</tr>
<tr>
<td>Is age 65 or over, actively working, has Medicare Parts A and B and ESRD</td>
<td>Is age 65 or over, has Medicare Parts A and B with ESRD</td>
<td>New or Existing Member(s) Medicare Primary. Must have Medicare Parts A and B with ESRD NO 30-month coordination period</td>
<td>New or Existing Member(s) Has Medicare A OR B, or Both ESRD, BCN Primary Required 30-month coordination period beginning with the first date of dialysis or transplant date. ESRD Medicare Primary Must complete the 30-month coordination period regardless of date of transplant.</td>
<td>New or Existing Member(s) Has Medicare A OR B, or Both ESRD, BCN Primary Required 30-month coordination period beginning with the first date of dialysis or transplant date. ESRD Medicare Primary Must complete the 30-month coordination period regardless of date of transplant.</td>
</tr>
<tr>
<td>Is age 65 with ESRD and has Medicare Parts A and B</td>
<td>Is under age 65 with ESRD and has Medicare Parts A and B</td>
<td>New or Existing Member(s) Medicare Parts A and B ESRD, BCN Primary Required 30-month coordination period beginning with the first date of dialysis or transplant date. ESRD Medicare Primary Must complete the 30-month coordination period regardless of date of transplant.</td>
<td>New or Existing Member(s) Medicare Part A &amp; B BCN Primary Required 30-month coordination period beginning with the first date of dialysis or transplant date. Medicare Primary Must complete the 30-month coordination period regardless of date of transplant.</td>
<td>New or Existing Member(s) Medicare Part A &amp; B BCN Primary Required 30-month coordination period beginning with the first date of dialysis or transplant date. Medicare Primary Must complete the 30-month coordination period regardless of date of transplant.</td>
</tr>
<tr>
<td>Is under age 65 with ESRD and has Medicare Part A, but NOT Medicare Part B</td>
<td>Is under age 65 with ESRD and has Medicare Part A, but NOT Medicare Part B</td>
<td>New or Existing Member(s) Medicare Part A, NO Part B BCN Primary Required 30-month coordination period for all A &amp; B benefits. After 30th month, BCN primary for Part B benefits only. Medicare Primary, for Part A Benefits only Must complete the 30-month coordination period regardless of date of transplant.</td>
<td>New or Existing Member(s) Medicare Part A, NO Part B BCN Primary Required 30-month coordination period for all A &amp; B benefits. After 30th month, BCN primary for Part B benefits only. Medicare Primary, for Part A Benefits only Must complete the 30-month coordination period regardless of date of transplant.</td>
<td>New or Existing Member(s) Medicare Part A, NO Part B BCN Primary Required 30-month coordination period for all A &amp; B benefits. After 30th month, BCN primary for Part B benefits only. Medicare Primary, for Part A Benefits only Must complete the 30-month coordination period regardless of date of transplant.</td>
</tr>
</tbody>
</table>
Enrollment/Change of Status Form — Overview ...................... 6-1
Subscriber new enrollment ..................................................... 6-3
Use the ECOS Form to enroll new subscribers ...................... 6-6
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Add members ........................................................................... 6-9
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  (ECOS Form, page 3) ............................................................ 6-19
**Enrollment/Change of Status Form — Overview**

**About the Enrollment/Change of Status form**

The ECOS form is used to report many routine membership changes, including:

- Enrollment
- Termination
- Contract changes
- Name changes
- Address changes
- Reinstatement
- COBRA
- New physician selection

**When to report changes**

Enrollments, membership changes, qualifying events (births, marriages) and terminations must be reported within 31 calendar days of the event. Timely reporting ensures that subscribers and their dependents have coverage when they need it. It also ensures that you don’t pay for coverage that’s not used.

BCN will not accept retroactive terminations or additions from your group more than 31 calendar days after the member’s change in status or the qualifying event. Additions and changes not reported within 31 calendar days of the event must be held until your group’s next open enrollment period.

**Patient Protection and Affordable Care Act**

Any eligibility and status changes that your group requests are understood to be compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Your group agrees to abide by all applicable state and federal law, including but not limited to the Patient Protection and Affordable Care Act.
Submitting the ECOS form

Submit the form to BCN within the 31-day required time period to:
Membership — Mail Code H300
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

Note: Do not mail ECOS forms with your premium payment. This could delay processing.

When you have someone who needs medical care immediately, call Group Inquiry at 1-800-970-6684 and request an urgent enrollment.

Processing the ECOS form

BCN begins processing ECOS forms as soon as they are received. If the form is complete and contains all BCN eligibility criteria, the member receives a BCN ID card and other member material within five to seven business days.

A BCN representative will notify you if the request cannot be processed for one of these reasons:

- The request arrived after the 31-day deadline.
- The data do not meet BCN's eligibility criteria as presented in the Group Enrollment and Coverage Agreement.
- The form was incomplete.
- The form was illegible.
- Supporting documentation was missing.
- The group representative signature is missing.
### Subscriber new enrollment

**Timing**

- Submit an ECOS form within 31 calendar days to enroll the following individuals:

<table>
<thead>
<tr>
<th>To Enroll</th>
<th>Coverage Effective Date</th>
<th>Additional Documents</th>
</tr>
</thead>
</table>
| Employers and owners               | ✓ Effective date of new group or in accordance with the terms specified in the Group Enrollment and Coverage Agreement  
瞭   ✓ At annual open enrollment         | None                                                                                   |
| Full-time workers (full-time and contract) and dependents | ✓ Coverage for new hires and rehires is effective according to the terms specified in the Group Enrollment and Coverage Agreement.  
瞭   ✓ At annual open enrollment, provided the new hire/rehire period is met. | None                                                                                   |
| Subscriber and dependents due to loss of coverage | ✓ Date of cancellation of the previous coverage with no lapse in coverage  
瞭   ✓ At annual open enrollment  
瞭   ✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement. | Letter from former health insurance carrier or group showing loss of coverage |
## Subscriber new enrollment (continued)

### Timing
Submit the ECOS form within 31 calendar days to enroll the following individuals:

<table>
<thead>
<tr>
<th>To Enroll</th>
<th>Coverage Effective Date</th>
<th>Additional Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber and dependent transfers from other Michigan Blue Cross Blue Shield products (new-hires only)</td>
<td>✓ Date of hire/new hire waiting period may be waived at discretion of the group for those transferring directly from another Michigan Blue Cross Blue Shield product</td>
<td>None</td>
</tr>
<tr>
<td>Subscriber and dependents at open enrollment</td>
<td>✓ Contact your Blues sales representative or agent for the specific date</td>
<td>None</td>
</tr>
</tbody>
</table>
| Spouse or dependent due to survivorship clause                            | ✓ Termination of subscriber contract  
✓ Group must have survivorship clause approved by BCN | Enrollment/Change of Status form completed by surviving spouse                        |
| Subscriber who previously declined coverage                               | ✓ Date of cancellation of the previous coverage with no lapse in coverage  
✓ At annual open enrollment  
✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement | Letter from former health insurance carrier or group showing loss of coverage          |
### Subscriber new enrollment (continued)

**Timing**
- Submit the ECOS form within 31 calendar days of effective date to enroll the following individuals:

<table>
<thead>
<tr>
<th>To Enroll</th>
<th>Coverage Effective Date</th>
<th>Additional Documents</th>
</tr>
</thead>
</table>
| Subscriber and dependent who initially had other group coverage and the group contribution ceased | ✓ Date of cancellation of the previous coverage with no lapse in coverage  
✓ At annual open enrollment  
✓ Must have satisfied new hire/rehire waiting period according to the Group Enrollment and Coverage Agreement | Letter from group indicating loss of contribution |
| Subscriber and dependent with dependent acquired through marriage, birth, adoption or placement for adoption | ✓ Date of event  
✓ At annual open enrollment | Adoption papers or documents verifying intent to adopt, if applicable |
**Use the ECOS Form to enroll new subscribers**

<table>
<thead>
<tr>
<th>Subscriber sections</th>
<th>The subscriber enters the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Social Security Number, last name, first name, middle initial, marital status, gender and date of birth</td>
</tr>
<tr>
<td></td>
<td>- Street address, city, state and zip code</td>
</tr>
<tr>
<td></td>
<td>- County name for home address, country name (if other than USA)</td>
</tr>
<tr>
<td></td>
<td>- Primary and secondary phone number, indicating if these are home, work or cell phones</td>
</tr>
<tr>
<td></td>
<td>- Email address</td>
</tr>
<tr>
<td></td>
<td>- All persons to be added (spouse, dependents), with names, gender, dates of birth, Social Security Numbers (required) and relationship codes</td>
</tr>
<tr>
<td></td>
<td>N – Child (by Birth or Adoption)</td>
</tr>
<tr>
<td></td>
<td>S – Stepchild</td>
</tr>
<tr>
<td></td>
<td>P - Principal Support</td>
</tr>
<tr>
<td></td>
<td>A – Child Adoption in Process (court order required)</td>
</tr>
<tr>
<td></td>
<td>L – Legal Guardianship (court order required)</td>
</tr>
<tr>
<td></td>
<td>SD – Sponsored Dependent (documentation required)</td>
</tr>
<tr>
<td></td>
<td>C – Court order coverage (QMCSO) (court order required)</td>
</tr>
<tr>
<td></td>
<td>D – Disabled Child (PA 218) (physician statement required)</td>
</tr>
<tr>
<td></td>
<td>M – Medicare (complete for anyone on the application who has Medicare Parts A and B)</td>
</tr>
<tr>
<td></td>
<td>- Permanent address of spouse or dependents if different from the subscriber</td>
</tr>
<tr>
<td></td>
<td>- Coordination of benefits Information, indicating if the subscriber, spouse or dependent maintains other health care coverage</td>
</tr>
</tbody>
</table>

After entering the information, the subscriber must sign and date the form in the signature section.
Use the ECOS form to enroll new subscribers (continued)

Group information at the top of the form

The group enters the following at the top of the page:
- BCN group identification number
- Subgroup identification number
- BCN class identification number.

The group representative must sign and date the form in the signature section.

Group information after subscriber section

These boxes follow the “Health Savings and Flexible Spending Account” options
- Group name, employee Identification/badge/department number, if applicable
- Date of hire and effective date
- Type of enrollment
- Average hours worked and job title
- COBRA information, if applicable
- If enrollment is due to loss of eligibility
- Medicare status (complete for anyone on the application who has Medicare Parts A and B)
### Subscriber New Enrollment (ECOS Form, page 2)

#### Subscriber information
- **Date:**
- **Social Security/TIN number (required):**
- **Subscriber last name:**
- **Subscriber first name:**
- **M.I.:**
- **Marital status:**
- **Gender:**
- **City:**
- **State:**
- **ZIP code:**

#### County
- **Country:**
- **Country if other than USA:**

#### Primary telephone number
- **Home:**
- **Work:**
- **Cell:**

#### Secondary telephone number
- **Home:**
- **Work:**
- **Cell:**

#### List all persons to be covered:
- **Spouse:**
- **Dep. 1:**
- **Dep. 2:**
- **Dep. 3:**
- **Dep. 4:**

#### Coordination of benefits information
- **Do you, your spouse or dependents have other health care coverage?**
- **Yes**
- **No**
- **If "Yes," complete below:**
- **Check here if this applies to all members on the contract:**

#### I have read and understand the conditions of this form.
- **Subscriber signature:**
- **Date:**

#### Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections
- **FSA**
- **HRA**
- **HSA**
- **HSA Opt out**
- **Blue Cross product indicator code**

#### Employer/group use only
- **Group name**
- **Employer reference ID**
- **Department ID**
- **Benefit code**
- **Plan code**
- **Date of hire**
- **Effective date**

#### Check coverage if applicable:
- **Medical**
- **Vision**
- **Dental**
- **Pharmacy**

#### OCOBA enrollment
- **Check reason:**
- **Termination**
- **Layoff**
- **Reduction of hours**
- **Divorce or legal separation**
- **Previous contract number**
- **Original qualifying date**

#### Loss of eligibility (prior coverage)
- **Yes**
- **No**
- **If "Yes," complete:**

#### Medicare
- **Medicare primary**
- **Medicare A effective date**
- **Medicare B effective date**
- **Medicare Part D effective date**

---

6-8 Enrollment/Change of Status Form
bcbsm.com
Group Inquiry: 1-800-970-6684

January 2017
### Add members

**Timing**
- Submit the ECOS form within 31 calendar days of effective date to add the following dependents to an existing contract:

<table>
<thead>
<tr>
<th>To Add</th>
<th>Coverage Effective Date</th>
<th>Additional Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse or dependent child</strong></td>
<td>✓ Date of marriage, birth</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse or dependent due to loss of coverage</strong></td>
<td>✓ Loss of coverage date if reported within 31 calendar days of the event with no lapse in coverage</td>
<td>Letter from former health plan or employer stating coverage has been terminated</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td></td>
</tr>
<tr>
<td><strong>Children by legal adoption or guardianship or petition for legal guardianship</strong></td>
<td>✓ Date of legal adoption, guardianship or petition filing</td>
<td>✓ Court order</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td>✓ Documentation verifying guardianship (must be received within 12 months of filing petition)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Documentation verifying intent to adopt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Petition for guardianship</td>
</tr>
<tr>
<td><strong>Principal support of dependent</strong></td>
<td>✓ Date that established nine-month criteria is met</td>
<td>✓ Most recent federal income tax return form</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Notarized statement verifying support if taxes have not yet been filed</td>
</tr>
</tbody>
</table>

**bcbsm.com**
Group Inquiry: 1-800-970-6684
Add members (continued)

**Timing**

✓ Submit the ECOS form within 30 calendar days of effective date to add the following dependents to an existing contract:

<table>
<thead>
<tr>
<th>To Add</th>
<th>Coverage Effective Date</th>
<th>Additional Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returning military veterans</td>
<td>✓ Date of discharge</td>
<td>Proof of discharge</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td></td>
</tr>
<tr>
<td>Qualified medical support order</td>
<td>✓ Date of court order if received within 31 calendar days; otherwise, date of receipt</td>
<td>Copy of Qualified Medical Child Support Order or specified section of the Divorce Degree</td>
</tr>
<tr>
<td>Incapacitated or disabled children over age 26</td>
<td>✓ Subscriber’s initial effective date</td>
<td>Physician’s certificate prior to end of year dependent turns 26</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td></td>
</tr>
<tr>
<td>Spouse or dependents due to the marriage, birth, adoption of another dependent</td>
<td>✓ Date of event</td>
<td>Adoption papers or documents verifying intent to adopt or petition for guardianship</td>
</tr>
<tr>
<td></td>
<td>✓ Annual open enrollment</td>
<td></td>
</tr>
<tr>
<td>Spouse or dependents due to a group-wide change</td>
<td>Date of the change</td>
<td>None</td>
</tr>
<tr>
<td>Spouse or dependents due to a change in the group contribution</td>
<td>Date of the change</td>
<td>Letter from group indicating change in contribution</td>
</tr>
</tbody>
</table>
Delete members: Termination

Termination options

A member’s coverage is effective until midnight of the termination date indicated on the Enrollment/Change of Status form.* The following coverage termination options apply:

- **Contract Termination** — Cancels the coverage of the subscriber, spouse and dependents on the contract
- **Spouse Termination** — Cancels the coverage of the spouse only
- **Dependent Termination** — Cancels the coverage of the dependents listed.

Timing

Please note: BCN must receive all terminations from your group within 31 days following the member’s change in status or the effective date.
## Delete members: Termination (continued)

<table>
<thead>
<tr>
<th>Type of Termination</th>
<th>When to report</th>
<th>Termination Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subscriber</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Termination</td>
<td>Within 30 calendar days of the event</td>
<td>Date of event or the group’s personnel policy</td>
</tr>
<tr>
<td>✓ Lay-off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Reduced work hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ No longer wants coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Termination of COBRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subscriber retirement</strong></td>
<td></td>
<td>Date of retirement</td>
</tr>
<tr>
<td><strong>Subscriber death</strong></td>
<td>Within 30 calendar days of the event</td>
<td>Date of death</td>
</tr>
<tr>
<td><strong>Spouse or child death</strong></td>
<td>Within 30 calendar days of the event</td>
<td>Date of death</td>
</tr>
<tr>
<td><strong>Spouse — divorce</strong></td>
<td>Within 30 calendar days of the event</td>
<td>Date of divorce</td>
</tr>
<tr>
<td><strong>Dependent child Enters military service</strong></td>
<td>Within 30 calendar days of the event</td>
<td>Date of event</td>
</tr>
<tr>
<td><strong>Transfer to another subgroup/class or health insurance carrier</strong></td>
<td>Within 30 calendar days of the event</td>
<td>Effective date of coverage through new subgroup/class or open enrollment effective date</td>
</tr>
</tbody>
</table>
### Make other changes

<table>
<thead>
<tr>
<th><strong>Other changes</strong></th>
<th>The ECOS form can also be used to enter a name change (for example, after a subscriber gets married) or an address change. It can be used to reinstate a member or to change a member’s classification to COBRA.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timing</strong></td>
<td>Submit the ECOS form within 30 calendar days.</td>
</tr>
</tbody>
</table>
Use the ECOS form to make changes

Subscriber sections

The subscriber enters the following:

- Social Security Number, last name, first name, middle initial, marital status, gender and date of birth
- If new: home address beginning with street address, city, state and zip code
- If new: email address
- If new: county name for home address, country name (if other than USA)
- If new: primary and secondary phone numbers, indicating if these are home, work or cell phones
- All persons to be added or deleted (spouse, dependents), providing names, gender, date of birth, Social Security Number (required) and relationship code
  - N – Child (by Birth or Adoption)
  - S – Stepchild
  - P - Principal Support
  - A – Child Adoption in Process (court order required)
  - L – Legal Guardianship (court order required)
  - SD – Sponsored Dependent (documentation required)
  - C – Court order coverage (QMCSO) (court order required)
  - D – Disabled Child (PA 218) (physician statement required)
  - M – Medicare
- Permanent address of spouse or dependents if different from the subscriber
- If new: coordination of Benefits Information, indicating if the subscriber, spouse or dependent maintains other health care coverage

After entering the information, the subscriber must sign and date the form in the signature section.
Use the ECOS form to make changes (continued)

The group enters the following at the top of the page:
- BCN group identification number
- Subgroup identification number
- BCN class identification number.

The group representative must sign and date the form in the signature section.

These boxes follow the “Health Savings and Flexible Spending Account” options heading.
- Group name, employee Identification/badge/department number, if applicable
- Change desired and effective date of change
- Cancellation of subscriber, spouse or dependent and reason
- Loss of eligibility, if applicable
- Medicare status, if applicable
# Change of Status (ECOS Form, page 6)

## Subscriber Information

<table>
<thead>
<tr>
<th>New home street address</th>
<th>City*</th>
<th>State*</th>
<th>ZIP code*</th>
<th>Email*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country*</td>
<td>Country - if other than USA*</td>
<td>New primary phone*</td>
<td>Home*</td>
<td>Work*</td>
</tr>
</tbody>
</table>

## List All Persons to be Added or Deleted

<table>
<thead>
<tr>
<th>Spouse</th>
<th>Last name</th>
<th>First name</th>
<th>M/F</th>
<th>Gender</th>
<th>Date of birth</th>
<th>Non-U.S. citizen</th>
<th>Social Security number/TIN (required)</th>
</tr>
</thead>
</table>

## Coordination of Benefits Information

- Do you, your spouse or dependents have other health care coverage? [ ] Yes [ ] No
- If "Yes", complete below:
- Check here if this applies to all members on the contract:
- I have read and understand the conditions of this form, signature:
- Date:

## Health Savings, Health Reimbursement, and Flexible Spending Account Options

- [ ] FSA
- [ ] HRA
- [ ] HSA
- [ ] HSA opt out:

## Employer Group Use Only

<table>
<thead>
<tr>
<th>Group name</th>
<th>Employer reference ID</th>
<th>Department ID</th>
<th>Benefit code</th>
<th>Plan code</th>
</tr>
</thead>
</table>

## Check Reason for Change Below

- [ ] Marriage
- [ ] Loss of eligibility (prior coverage) [ ] COBRA enrollment
- [ ] Dependents [ ] Name change [ ] Open enrollment [ ] Address change
- [ ] Transfer/retire group/division/status [ ] New group/division/subgroup

## Check Type of Cancellation and Reason Below

- Type: [ ] Contract [ ] Spouse [ ] Dependents
- Reason: [ ] COBRA [ ] Death [ ] Left employment
- [ ] Divorce [ ] Dependent over age [ ] Other
- [ ] Retired [ ] Other insurance [ ] Last date of coverage:

## Loss of Eligibility (prior coverage)?

- [ ] Yes [ ] No
- If "Yes", complete below:

## Are Any Listed Members Enrolled in Medicare?

- [ ] Yes [ ] No
- If "Yes", check reason category:

## Contact Information

<table>
<thead>
<tr>
<th>Name (includes Blue Cross or BCN)</th>
<th>Contract holder name</th>
<th>Policy number</th>
<th>Termination date</th>
</tr>
</thead>
</table>

---

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
**Change primary care physicians**

**Changing primary care physicians**

Blue Care Network offers members these three ways to change their primary care physicians.

- Completing the Physician Selection/Change page of the Enrollment/Change of Status form
- Online at [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor)
- Calling Customer Service

**ECOS form**

Members can select or change their primary care physician by submitting an Enrollment/Change of Status form directly to BCN. Their new selection becomes effective two business days following the date of receipt of the form by BCN. See instructions that follow.

Note: The group representative does not need to sign the form.

**Internet access**

Members with Internet access can update their physician selection online at [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor). This feature offers several advantages:

- The change is made instantly.
- Members can view and select from the most current provider information on file with BCN.
- The site provides patient/provider matches based on member preferences, geography and the ages and gender of patients the doctor is accepting.
- Members can register their reasons for changing doctors and be assured that this information will be carefully tracked.

**Physician Selection form**

Members can select a new primary care physician by submitting a Physician Selection form to BCN. Please see section 1-5 of this manual for a copy of the form.

**Contacting BCN Customer Service**

Members can call BCN Customer Service at 1-800-662-6667. (Monday through Friday 8 a.m. to 5:30 p.m.) to update their physician selection. The new selection becomes effective two business days following the date of the call.
Use the ECOS form to change primary care physicians

**ECOS form**
Complete page 4 (Change of Status) of the ECOS form to select or change a primary care physician.

**Subscriber sections**
The subscriber enters the following:

- Subscriber social security number, BCN group number, subgroup number and class number.
- Each member’s last name, first name, physician’s last name and first name, PCP number, physician’s location and the reason for the PCP change. Indicate if the primary care physician has been seen in the last 12 months.
- The group/employer’s name and the physician change effective date.

The subscriber must sign and date the form.
Primary Care Physician Selection Form (ECOS Form, page 4)

If you are enrolling in Blue Cross Blue Shield of Michigan Personal Choice PPO or Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections on this form.

You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician.

Need information about available primary care physicians?

Our website, bcbsm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care physicians. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, obgyn or hospital group.

<table>
<thead>
<tr>
<th>Member information</th>
<th>Member's last name, first name</th>
<th>Physician last name, first name</th>
<th>Physician's NPI#</th>
<th>Physician address</th>
<th>If changing PCPs, list reason</th>
<th>Seen in the last 12 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Dep. 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Dep. 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Dep. 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Dep. 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>

I have read and understand the conditions of this form. Signature:

Return this form to start your health care partnership.

We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

For Blue Cross Blue Shield of Michigan: Fax your complete form to 1-866-900-2629 or 1-866-900-2829
Or mail to: Blue Cross Blue Shield of Michigan Membership and Billing - M.C. 610G P.O. Box 2260 Detroit, MI 48226

For Blue Care Network:
Fax your complete form to 1-877-218-1466
Or mail to: Blue Care Network Membership and Billing - M.C. H300 P.O. Box 5043 Southfield, MI 48066-5043

All changes become effective two business days after we receive this form — unless you request a later effective date.

You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must authorize the treatment you are receiving. Your treatment may not be covered until that occurs. You may request to change your primary care physician effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Section 7: Understanding Your Monthly Invoice

Understanding the monthly invoicing process ......................... 7-1
Call Group Inquiry ..................................................................... 7-3
Remitting payment..................................................................... 7-4

Group Authorization Agreement for Automatic Payments .... 7-5
Contract additions and terminations ......................................... 7-7

Your monthly invoice

Page 1 totals ........................................................................ 7-8
Payment coupon ..................................................................... 7-10
Premium detail by subscriber .................................................. 7-11
Understanding the monthly invoicing process

**Invoice**

Blue Care Network is a prepaid health plan. Each invoice reflects the premium due for the month to come. For example, the bill you receive in March will show your premium for April.

You should receive your invoice approximately 20-25 days before the first day of your coverage month. Your premium payment is due on the date stated on your invoice. If your group has more than one subgroup, you may receive a separate billing statement for each subgroup.

Your monthly invoice provides information about who’s covered under your group plan.

**Note:** Report all changes using an Enrollment/Change of Status form (see Section 6 for how to complete this form). Please do not indicate changes on the invoice. They will not be processed.

---

**Review your invoice each month.**

Because an invoice may have retroactive adjustments, check each invoice to make sure it accurately reflects members who were added or removed.

---

**How premiums are calculated**

BCN bills according to the diem billing method, which is based on a daily rate.

---

*continued*
Understanding the monthly invoicing process (continued)

**Online invoices**

Group invoices are available online from our Group Secured Services website at bcbsm.com. Using the eBilling tool, you can review and retrieve current and past invoices that may be up to two years old.

To request access to eBilling:

- Register your group on the Group Secured Services website at bcbsm.com. Select “Employer” at the top of the page (above the tabs in the blue bar) and then click login. If you are new to Group Secured Services select the “not registered” option under the login entry lines.

- If you are already registered with Group Secured Services, simply log in.

- Use the Add Services link on the Administration page to select eBilling. Within 24 hours of registration, you’ll be able to add this tool to your company administrator’s profile.

If you need technical assistance, please call 1-855 236-3178. If eBilling doesn’t appear as a service to add, please call our Web Support Help Desk at 1-877-258-3932.
Call Group Inquiry

If an expected enrollment, disenrollment or contract change is not on your billing statement, call Group Inquiry to verify that it will be on the next month’s billing statement. Any retroactive premium or credit will be automatically calculated by BCN.

Forms
To obtain a form for adding or deleting members or making other changes to your agreement with us, call Group Inquiry.

Call Group Inquiry
You can reach Group Inquiry (1-800-970-6684) Monday through Thursday from 8:30 a.m. to 5 p.m. and Friday from 9:30 a.m. to 5 p.m.
Remitting payment

Paying the bill
Pay what you’ve been billed, and allow the system to self-correct. Don’t make adjustments yourself. When sending your premium, always make sure your payment is for the “Balance Due” on the first page of your bill. Report all discrepancies directly to Group Inquiry.

Because BCN is a prepaid health plan, payment is due by the invoice due date. You can pay your invoice online with eBilling, or you can mail your payment to:

Blue Care Network
P.O. Box 33608
Detroit, MI 48232-5608

Paying by mail
Include the payment coupon when paying by mail. If you are paying for multiple subgroups, include each subgroup’s payment coupon. These coupons are read electronically. Returning them ensures payment is posted to your account accurately and without delay, so your account delinquent doesn’t become delinquent.

Do not enclose Enrollment/Change of Status forms with your payment.

Automated payment
Through BCN’s autopay program, your group can authorize BCN to deduct payments from a designated checking or savings account on the due date. There is no charge for the service. Autopay processing eliminates the possibility of late or delinquent payment. However, we will continue to send your invoice, unless you request otherwise.

You can elect automated payments through the eBilling application or by sending us the authorization form that appears on the next page. The form is also available online at bcbsm.com/employers/help/plan-documents-and-forms/managing-my-account/group-authorization-agreement-for-automatic-payments-form.html.
Group Authorization Agreement for Automatic Payments

<table>
<thead>
<tr>
<th>Group name:</th>
<th>Group decision maker:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN group ID:</td>
<td>Subgroup ID:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

Authorization for automatic payments

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my group’s checking/savings account amounts necessary to pay the premium owed by my group under my group’s BCN contract. This authority will remain in effect until I, or another group representative, notifies you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

<table>
<thead>
<tr>
<th>Bank name:</th>
<th>Branch:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

Please deduct my monthly BCN premium from (check one):

- □ Checking account (Please include a voided check when you return this form.)
- □ Savings account (Please include a voided deposit slip when you return this form.)

If you bank online, please write in your checking or savings account number and bank routing number.

Account number

Bank routing number

Signature of group decision maker: ____________________________ Date: __________________________

Requests received by the 5th of the month will take effect the following month. Withdrawals will occur each month on the date your premium payment is due. We will send you written notification of the date your automatic payments begin. Please fax, email or mail the completed form to:

Fax: 1-866-615-6793

Email: bcnaccountsreceivable@bcbsm.com

Mail: Blue Care Network
Collections - Mail Code C415
P.O. Box 5043
Southfield, MI 48086-5043

Blue Care Network use only

| Processor: | Process date: | Effective date: |

CF 10842 MAY 11
BCN’s goal is to have your payment posted within 48 hours. The following situations can cause delays in our processing your payment in a timely manner.

- **You sent payments to BCN’s Southfield office.** These payments must then be forwarded to the Detroit lockbox location, adding as many as three days for processing.
- **You didn’t include the payment coupon with your payment.** The bank forwards payment to BCN’s Southfield office for investigation and manual posting, adding as many as three days for processing.
**Contract additions and terminations**

**30-day policy**

Send us your contract enrollments and terminations within 30 calendar days of the effective date, not only for timely processing but for invoice accuracy. We won’t process changes sent after the effective date, unless your request for an exception is accepted.

If you calculate 30 calendar days from the effective date allowance, the addition or termination might not show on your invoice for up to four months.

**Invoice example**

This example illustrates the impact of the 30-day policy on your invoice.

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber gets married.</td>
<td>August 12</td>
</tr>
<tr>
<td>Group administrator submits form to BCN.</td>
<td>September 12</td>
</tr>
<tr>
<td>BCN runs billing for October.</td>
<td>Second week of September (new contract dependent not included)</td>
</tr>
<tr>
<td>BCN runs billing for November.</td>
<td>Second week of October (new contract dependent included)</td>
</tr>
<tr>
<td>November invoice shows retroactive premium.</td>
<td>For August, September, October, November</td>
</tr>
</tbody>
</table>
### Your monthly invoice: Page 1 totals

**Blue Care Network of Michigan**

- **Coverage Period**: 08/01/2013 to 08/31/2013
- **Invoice Number**: 13180002220
- **Page No**: 1

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Balance</td>
<td>$648.26</td>
</tr>
<tr>
<td>Payment(s) Received Since Last Invoice</td>
<td>$0.00</td>
</tr>
<tr>
<td>Balance Forward</td>
<td>$648.26</td>
</tr>
<tr>
<td>Adjustments (Details on Page 2)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Federal and State Taxes and Fees Adjustments</td>
<td>$0.00</td>
</tr>
<tr>
<td>Current Premium</td>
<td>$637.46</td>
</tr>
<tr>
<td>Federal and State Taxes and Fees</td>
<td>$5.40</td>
</tr>
<tr>
<td><strong>Balance Due By</strong>: 08/01/2013</td>
<td>$1,291.12</td>
</tr>
</tbody>
</table>

**FOR BILLING INQUIRIES, PLEASE CALL 1-800-970-6684**

**YOUR PAYMENT IS PAST DUE. IF PAYMENT IS NOT RECEIVED WITHIN 90 DAYS, YOUR BCN HEALTH CARE COVERAGE WILL BE CANCELLED. IF YOU HAVE ALREADY SENT YOUR PAYMENT, PLEASE DISREGARD THIS NOTICE.**

Non-payment of this bill will result in cancellation of this policy no less than 30 days from the due date.

Please use an enrollment change of status form and send all membership changes as they occur to:

Blue Care Network of Michigan

ATTN: Membership Department - MC C411

20090 Civic Center Drive

Southfield, MI 48076

Or fax the enrollment change of status form to: 877-345-1466

If BCN is deducting payment from your account, this invoice is informational only.

**KEEP THIS PORTION FOR YOUR RECORDS**

**PAYMENT COUPON**

Make check payable to BLUE CARE NETWORK OF MICHIGAN. Include your GROUP and/or SUBGROUP NUMBER(s) on the check and mail in the enclosed envelope to:

Blue Care Network

P.O. Box 35668

Detroit, MI 48212-3568

**GROUP**: [Redacted]

**INVOICE NUMBER**: 123456789012

**COVERAGE PERIOD**: 08/01/2013 to 08/31/2013

Amount Enclosed: $1,291.12

Your payment will be late if not received by: 08/01/2013

Please pay this amount: $1,291.12

**bcbsm.com**

Group Inquiry: 1-800-970-6684
Reading the invoice  The legend below corresponds to the key numbers on the preceding page.

1. Group name, contact name and address (Review to make sure information is correct.)
2. Your 12-digit group/subgroup number
3. Total subscribers and members being billed on this billing statement
4. Date invoice was generated
5. Previous balance: Total amount outstanding from previous months
6. Payments(s) received: Payments received by BCN since the last billing statement
7. Balance forward: Previous balance minus amount paid
8. Adjustments: Total of all the retroactive adjustments listed on the "Retroactive Adjustments By Subscriber" section and any manual account adjustments if applicable
9. Current premium: Total of all the premium amounts listed on the "Premium Detail By Subscriber" section
10. Balance due: What you need to pay by the due date
Your monthly invoice: payment coupon

(tear here) (tear here)

---------------------------------------------------------------------------------------------------------------
DO NOT FOLD OR STAPLE. PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT

1. PAYMENT COUPON

Make check payable to BLUE CARE NETWORK OF MICHIGAN. Include your GROUP and/or SUBGROUP NUMBER(s) on the check and mail in the enclosed envelope to:

BLUE CARE NETWORK OF MICHIGAN
P.O. BOX 33608
DETROIT MI 48232-5608

2. SHOEBOX REPAIR SHOP

GROUP 00001
SUBGROUP 070720000669
INVOICE NUMBER
COVERAGE PERIOD
04/01/2004 to 04/30/2004

3. AMOUNT ENCLOSED:

YOUR PAYMENT WILL BE LATE IF NOT RECEIVED BY: 04/01/2004
AMOUNT: $2,177.67

4. 

Reading the invoice

The legend below corresponds to the key numbers above.

1. Payment coupon: Send this page with monthly premium payment.
2. Lockbox address: Send payment to this address.
3. Amount enclosed: Enter amount remitted.
4. Premium due date and amount: Send this total amount by due date to avoid delinquency.
Your monthly invoice: premium detail by subscriber

**Premiums**
The following sample invoice identifies premiums billed for each subscriber.

### FEES AND DISCOUNTS BY GROUP

<table>
<thead>
<tr>
<th>Adjustment Reason</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal and State Taxes and Fees, Current</td>
<td>$58.92</td>
</tr>
<tr>
<td>Federal and State Taxes and Fees, Retro</td>
<td>$1.00</td>
</tr>
</tbody>
</table>

**TOTAL FEDERAL AND STATE TAXES FOR GROUP: 00108227**

$59.92

### RETROACTIVE ADJUSTMENTS BY SUBSCRIBER

**SUBGROUP: 0001 - CLASS: 0001 - ACTIVE**

<table>
<thead>
<tr>
<th>Subscriber ID</th>
<th>Subscriber Last Name</th>
<th>Subscriber First Name</th>
<th>Coverage From</th>
<th>Coverage Through</th>
<th>Monthly Count</th>
<th>Adj. Size</th>
<th>Adj. Days</th>
<th>Adj. Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>6790</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>06/01/13</td>
<td>06/30/13</td>
<td>Y</td>
<td>3</td>
<td>30</td>
<td>MR</td>
<td>$118.20</td>
</tr>
</tbody>
</table>

### TOTAL ADJUSTMENTS FOR SUBGROUP 0001, CLASS 0001**

$118.20

### TOTAL ADJUSTMENTS FOR SUBGROUP 0001**

$118.20

### TOTAL ADJUSTMENTS FOR GROUP: 00108227**

$118.20

### PREMIUM DETAIL BY SUBSCRIBER

**SUBGROUP: 0001 - CLASS: 0001 - ACTIVE**

<table>
<thead>
<tr>
<th>Subscriber ID</th>
<th>Subscriber Last Name</th>
<th>Subscriber First Name</th>
<th>Coverage From</th>
<th>Coverage Through</th>
<th>Monthly Count</th>
<th>Adj. Size</th>
<th>Adj. Days</th>
<th>Adj. Type</th>
<th>Plan(s)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>345</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
<tr>
<td>790</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>V</td>
<td>3</td>
<td>31</td>
<td>M.R</td>
<td>$1,024.41</td>
<td></td>
</tr>
<tr>
<td>410</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$1,024.41</td>
<td></td>
</tr>
<tr>
<td>1628</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
<tr>
<td>680</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
<tr>
<td>265</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>W</td>
<td>2</td>
<td>31</td>
<td>M.R</td>
<td>$906.21</td>
<td></td>
</tr>
<tr>
<td>3790</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Y</td>
<td>2</td>
<td>31</td>
<td>M.R</td>
<td>$906.21</td>
<td></td>
</tr>
<tr>
<td>6063</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
<tr>
<td>5210</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
<tr>
<td>2930</td>
<td>xxxxxxxx</td>
<td>xxxxxxxx</td>
<td>07/01/13</td>
<td>07/31/13</td>
<td>Z</td>
<td>1</td>
<td>31</td>
<td>M.R</td>
<td>$394.00</td>
<td></td>
</tr>
</tbody>
</table>

### TOTAL CURRENT PREMIUM FOR SUBGROUP 0001, CLASS 0001**

$7,013.24

### TOTAL CURRENT PREMIUM FOR SUBGROUP 0001**

$7,013.24

### TOTAL CURRENT PREMIUM FOR GROUP: 00108227**

$7,013.24
Your monthly invoice: premium detail by subscriber

Reading the invoice

The legend below corresponds to the key numbers on the preceding page.

1. Coverage period: Premiums are billed for this month
2. Total adjustments: Computed under each class ID and for the entire group, which corresponds to the total of all retroactive adjustments
3. Premium amount: Amount billed for each subscriber
4. Member count by plan: Shows sponsored dependents (SD), Medicare supplemental (MS) or Medicare Advantage (MA) members
5. Total premiums billed for the entire group, which corresponds to the total billed under all combined classes
# Section 8: Member Information

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members’ rights and responsibilities</td>
<td>8-1</td>
</tr>
<tr>
<td>Advance directives</td>
<td>8-4</td>
</tr>
<tr>
<td>New member materials</td>
<td>8-5</td>
</tr>
<tr>
<td>Member information</td>
<td>8-6</td>
</tr>
<tr>
<td>Benefit and claim issues</td>
<td>8-7</td>
</tr>
<tr>
<td>Coordination of benefits</td>
<td>8-8</td>
</tr>
<tr>
<td>Member Grievance Program</td>
<td>8-9</td>
</tr>
</tbody>
</table>
Members’ rights and responsibilities

**Member Rights**

Blue Care Network believes that members are an essential part of the health care team and have responsibility for their own health.

All members have the right to:

- Receive information about their health 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 conditions, regardless of cost or benefit coverage
- Participate with practitioners in decision making regarding their health care
- Expect confidentiality regarding their care and that BCN adheres to strict internal and external guidelines concerning the members' personal 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 their health care by contacting Customer Service or submitting a formal, written complaint through the BCN Member Grievance program
- Receive clear and understandable written information about BCN, its services, its practitioners and providers, and their rights and responsibilities
- Review their medical records at their primary care physician’s office by scheduling an appointment during regular business hours
- Make recommendations regarding BCN’s member’s rights and responsibilities policies

*continued*
Members’ rights and responsibilities (continued)

Member Rights (continued)

- Request the following information from BCN:
  - The current BCN provider network for their plan
  - The professional credentials of the health care providers who are participating providers with BCN, 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 BCN and a participating provider

continued
Members’ rights and responsibilities (continued)

<table>
<thead>
<tr>
<th>Member Responsibilities</th>
<th>All members have the responsibility to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Read their Certificate of Coverage and applicable riders, their Member Handbook and all other materials for members, and call Customer Service with any questions</td>
</tr>
<tr>
<td></td>
<td>• Coordinate all nonemergency care through their primary care physician</td>
</tr>
<tr>
<td></td>
<td>• Use the BCN provider network unless otherwise referred and approved by BCN and their primary care physicians</td>
</tr>
<tr>
<td></td>
<td>• Comply with the plans and instructions for care that they have agreed to with their practitioners</td>
</tr>
<tr>
<td></td>
<td>• Provide, to the extent possible, complete and accurate information that BCN and its practitioners and providers need in order to provide care for them</td>
</tr>
<tr>
<td></td>
<td>• Make and keep appointments for nonemergent medical care, or call their doctors’ offices if they need to cancel appointments</td>
</tr>
<tr>
<td></td>
<td>• Participate in the medical decisions regarding their health</td>
</tr>
<tr>
<td></td>
<td>• Be considerate and courteous to practitioners, providers, their staff, other patients and BCN staff</td>
</tr>
<tr>
<td></td>
<td>• Notify BCN of address changes and additions or deletions of dependents covered by their contracts</td>
</tr>
<tr>
<td></td>
<td>• Protect their BCN ID cards against misuse and call Customer Service immediately if a card is lost or stolen</td>
</tr>
<tr>
<td></td>
<td>• Report to BCN all other health care coverage or insurance programs that cover their health and their family’s health</td>
</tr>
<tr>
<td></td>
<td>• Participate in understanding their health problems and developing mutually agreed-upon treatment goals</td>
</tr>
</tbody>
</table>

continued
Advance directives

Members have the right to make advance directives

An advance directive document indicates a member's desired future treatment choices. It is intended for use when the member is unable to make a choice.

BCN recognizes and respects the right of all members to accept or refuse medical treatment. We require all primary care physicians to ask all adult members, age 18 and older, if they have an advance directive and to document the response in the medical record.

BCN does not require members to execute an advance directive as a condition of membership or to receive care. Nor does BCN discriminate based on whether a member has an advance directive.
New member materials

New member kits

As soon as we receive a list of new members, we send them ID cards and a new Member Handbook.

- **Identification Card**
  This card identifies the kind of coverage the member has. Encourage your enrolled members to carry their BCN identification cards at all times. They may be asked to show their cards when using benefits.

- **Member Handbook**
  This reference tool helps members understand how their BCN coverage works. It also includes the following personalized information:
  
  — A list of members on the contract and the primary care physician BCN has on record for each
  — A benefit chart that defines coverage for the most-often used services

Healthy Blue Living<sup>SM</sup> books also include plan requirements and the steps members must take to pay the least for care. They also receive a qualification form with return envelope.
**Member information**

**Coverage documents**

Members can get details about their coverage from the following documents:

- **Certificate of Coverage**
  This legal document, approved by the Department of Insurance and Financial Services, includes:
  - **General Provisions**
    Describes the rules of the BCN health coverage plan
  - **Your Benefits**
    A detailed description of the member’s health care benefits, including exclusions and limitations

- **Riders**
  These documents add, delete or amend the terms of coverage.

Members can view their current certificates and riders by signing into their account at [bcbsm.com](http://bcbsm.com). Those without Internet access can call Customer Service (1-800-662-6667) and request print materials.

**BCN connects with members**

Blue Care Network communicates with members regularly through the following means.

- **Publications**
  BCN’s *Good Health* magazine is published twice yearly. It provides enrolled members with preventive health guidelines, healthy living tips and inspiring features.

- **Reminders**
  Through various mailings, we remind members to get health checkups, screenings or immunizations
**Benefit and claim issues**

**If a member gets a bill**
Occasionally, members may have to pay for a covered service. For example, if they need emergency care while traveling, they may be asked to pay at the time they receive care.

In the unlikely event that your members receive a bill, refer them to Customer Service. Also tell them to send the bill within 12 months of its receipt to:

Member Inquiry  
Blue Care Network  
P.O. Box 68767  
Grand Rapids, MI 49516-8767

The following information must be included:

- Itemized description identifying the provider, date of service, procedure and diagnosis codes and associated provider fees
- Subscriber or dependent's name, address and telephone number
- Contract number as it appears on the identification card
- Proof of payment (receipt or canceled check)
- Treatment record or emergency report
- Name and dosage of any prescription drugs, as well as the original prescription receipt

**When a bill is denied**
Life-threatening or accidental emergency care is always covered. If a member claim meets reimbursement criteria, it is paid, less any applicable copayment.

Sometimes, however, payment is denied. For example, if a member receives services without authorization from the primary care physician, the subscriber will be responsible for the charges.

If a claim is denied, the subscriber may appeal the decision by following the steps in the Blue Care Network grievance procedure described at the end of this section.
Coordination of benefits

Maximum benefit

We regularly send all members coordination of benefits questionnaires, asking if they have other-than-BCN medical and prescription coverage. Coordination of benefits may reduce out-of-pocket expenses.

Members who have BCN coverage may be eligible for coordination of benefits if:

- They or their dependents are also covered by a spouse’s group health plan or by some other type of insurance, such as automobile, home or workers’ compensation
- They or their dependents have Medicare coverage
- Their children are covered through a divorced spouse’s health care plan

Note: Members may also receive a COB questionnaire if they are involved in an auto accident, suffer a work-related injury or have an accidental injury (slip and fall).

Updated COB information helps facilitate claims processing

Encourage employees to return the completed coordination of benefits questionnaire as quickly as possible so their claims can be processing speedily. They can also complete the form online at bcbsm.com.

Remind subscribers to tell their health care provider if they or their family members have coverage under more than one health plan.
**Member grievance program**

**Appealing a payment decision**

BCN has a formal appeal and grievance process that members can use when they have issues or concerns they can’t resolve with their physician or by consulting with a Customer Service representative.

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

**ERISA and non-ERISA group procedures**

Members follow different procedures depending on whether their group is ERISA-qualified.

- **ERISA-qualified**
  A subscriber, including his or her qualified dependents, has the right to bring a civil action against BCN after completing the BCN internal grievance procedures.

- **Non-ERISA group**
  Subscribers and their dependents must exhaust all grievance steps — including the external review by the Michigan Department of Insurance and Financial Services — before filing a civil action.

**Grievance policy online or on request**

Members can request a copy of BCN’s formal grievance policy from Customer Service by calling 1-800-662-6667.

Members can also view the grievance policy online at bcbsm.com/BCNresolveproblems.
Section 9: Getting Questions Answered

Where to Get Your Questions Answered — Group ...................... 9-1
Where to Get Your Questions Answered — Member ................. 9-2
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Where to Get Your Questions Answered — Group

<table>
<thead>
<tr>
<th>For group representative with questions about</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit changes</td>
<td>Your Blues sales representative or independent agent</td>
</tr>
<tr>
<td>• Premium rates</td>
<td></td>
</tr>
<tr>
<td>• Premium rate renewals</td>
<td></td>
</tr>
<tr>
<td>• Open enrollment kits</td>
<td></td>
</tr>
<tr>
<td>• Membership eligibility</td>
<td>Regional Sales Office or Group Inquiry 1-800-970-6684 Monday through Thursday 8:30 a.m. to 5 p.m. Friday 9:30 a.m. to 5 p.m.</td>
</tr>
<tr>
<td>• Billing</td>
<td></td>
</tr>
<tr>
<td>• Enrollment/change form processing</td>
<td></td>
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<tr>
<td>• Monthly invoice</td>
<td></td>
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<tr>
<td>• Identification cards</td>
<td></td>
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<tr>
<td>• Seeking Services</td>
<td></td>
</tr>
<tr>
<td>• Claims</td>
<td>Regional Sales Office or Field Services 1-877-465-5120</td>
</tr>
<tr>
<td>• Benefits</td>
<td></td>
</tr>
<tr>
<td>• Physician referral</td>
<td></td>
</tr>
<tr>
<td>• Group education</td>
<td></td>
</tr>
<tr>
<td>• Technical field support</td>
<td></td>
</tr>
<tr>
<td>Information materials — forms by fax</td>
<td>Fax: 1-866-237-5322</td>
</tr>
<tr>
<td>Chronic condition management nurse line</td>
<td>1-800-392-4247</td>
</tr>
<tr>
<td>Anti Fraud Hotline</td>
<td>1-800-482-3787</td>
</tr>
<tr>
<td>BCN information</td>
<td>bcbsm.com</td>
</tr>
<tr>
<td>• History</td>
<td></td>
</tr>
<tr>
<td>• Executive staff</td>
<td></td>
</tr>
<tr>
<td>• Network</td>
<td></td>
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<tr>
<td>• Programs</td>
<td></td>
</tr>
<tr>
<td>Register for eMCS</td>
<td>bcbsm.com</td>
</tr>
</tbody>
</table>
## Where to Get Your Questions Answered — Member

<table>
<thead>
<tr>
<th>For members with questions about:</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Eligibility</td>
<td>BCN Customer Service 1-800-662-6667 (Or the number at the back of their ID card) 711 TTY users Monday through Friday 8 a.m. to 5:30 p.m.</td>
</tr>
<tr>
<td>✔ Benefits</td>
<td></td>
</tr>
<tr>
<td>✔ Physician referral</td>
<td></td>
</tr>
<tr>
<td>✔ Claims</td>
<td></td>
</tr>
<tr>
<td>✔ Identification card requests</td>
<td></td>
</tr>
<tr>
<td>Chronic condition management programs</td>
<td>1-800-392-4247</td>
</tr>
<tr>
<td>24-hour Nurse Advice Line. answers to health care questions from registered nurses</td>
<td>1-855-624-5214</td>
</tr>
<tr>
<td>Behavioral health services</td>
<td>1-800-482-5982</td>
</tr>
<tr>
<td>Care while traveling</td>
<td>1-80-810-BLUE (2583)</td>
</tr>
<tr>
<td>BCN information</td>
<td>bcbsm.com</td>
</tr>
<tr>
<td>✔ Customer Service information</td>
<td></td>
</tr>
<tr>
<td>✔ Health guidelines</td>
<td></td>
</tr>
<tr>
<td>✔ Programs</td>
<td></td>
</tr>
<tr>
<td>✔ Physician directory and selection application</td>
<td></td>
</tr>
</tbody>
</table>
**Group Inquiry**

**When to call Group Inquiry**
This unit serves groups, group administrators, managing agents and agents. Group Inquiry representatives coordinate the resolution of group-level membership and billing inquiries including:

- Verifying contracts and member status
- Determining member eligibility
- Explaining member-level underwriting guidelines
- Resolving membership discrepancies
- Coordinating the resolution of group billing issues

**Contact**
The Group Inquiry unit telephone number is 1-800-970-6684. Representatives are available Monday through Thursday 8:30 a.m. to 5 p.m. and Friday 9:30 a.m. to 5 p.m.
**Field Services**

<table>
<thead>
<tr>
<th>When to call Field Services</th>
<th>Field Services representatives serve groups, managing agents and agents in the following ways:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Clarifying benefit-level coverage</td>
</tr>
<tr>
<td></td>
<td>✓ Explaining benefits</td>
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<tr>
<td></td>
<td>✓ Resolving group-level claim issues</td>
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<tr>
<td></td>
<td>✓ Resolving group-level quality of care or service issues</td>
</tr>
<tr>
<td></td>
<td>✓ Providing group education on BCN administrative processes</td>
</tr>
<tr>
<td></td>
<td>✓ Providing technical field support to your BCBSM sales representative or your independent agent</td>
</tr>
</tbody>
</table>

| Contact | To find your BCN Field Services representative, call 1-877-465-5120. |
When to call your Blues sales rep

BCBSM Marketing staff can answer questions about the following:
- Premium rates
- Premium rate renewals
- Monthly invoice
- Enrollment kits
- Identification cards
- Membership eligibility
- Enrollment/change form processing
- Benefit clarification
- Billing questions
- Claims questions — if unresolved at the member level (Members should first contact Customer Service at 1-800-662-6667 or the number at the back of their card.)
- Physician referral questions
- Group education
- Technical field support
Materials and Supply Requests

Statewide Forms by Fax

BCN publishes informational materials for members and group administrators.

Group administrators can request materials by completing the forms-by-fax form on the following page and faxing it to 248-455-3651
<table>
<thead>
<tr>
<th>FORM NAME</th>
<th>DESCRIPTION</th>
<th>FORM Number</th>
<th>NUMBER requested (Limit of 25 per piece)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group publications</td>
<td>BLUE ElectPlus the value of an HMO + flexibility (brochure)</td>
<td>CB11788</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BCN HRA HMO: a fresh solution to a healthier bottom line (brochure)</td>
<td>CB10836</td>
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<tr>
<td></td>
<td>Confidence comes with every card (folder with pockets)</td>
<td>CB11223</td>
<td></td>
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<tr>
<td></td>
<td>Field and Customer Service</td>
<td>CF11805</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BCN HSA HMO® Health Savings Account Employer Guide</td>
<td>CB12521</td>
<td></td>
</tr>
<tr>
<td>Member publications</td>
<td>24/7 online health care</td>
<td>CF15546</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BCN HSA HMO® Health Savings Account Member Guide</td>
<td>CB12522</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blue Care Network’s Healthy Blue HMO HRA (brochure)</td>
<td>CB10853</td>
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</tr>
<tr>
<td></td>
<td>Blue ElectPlus self-referral option (two-sided flier)</td>
<td>CF11944</td>
<td></td>
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<tr>
<td></td>
<td>Coverage goes with you (BlueCard travel benefits brochure)</td>
<td>CF2448</td>
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<tr>
<td></td>
<td>Custom Drug List Quick Guide (brochure)</td>
<td>CB13256</td>
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<tr>
<td></td>
<td>Custom Select Drug List Quick Guide (brochure)</td>
<td>CB13584</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FYI: About coordination of benefits (one-page flier)</td>
<td>CF7288</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Are you ready to quit using tobacco?</td>
<td>CF15443</td>
<td></td>
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<tr>
<td></td>
<td>FYI: BCN member resources</td>
<td>CF14803</td>
<td></td>
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<tr>
<td></td>
<td>FYI: BCN Service Area Map (one-page flier)</td>
<td>CB10529</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FYI: Behavioral health coverage (one-page flier)</td>
<td>CF9000</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Blue Cross® Health &amp; Wellness for Blue Care Network</td>
<td>CB8046</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Durable medical equipment or diabetic supplies (one-page flier)</td>
<td>CF10849</td>
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<td></td>
<td>FYI: Generic drugs save you money (one-page flier)</td>
<td>CF9001</td>
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<tr>
<td></td>
<td>FYI: Have a health-related question? Call our 24-hour Nurse Advice Line</td>
<td>CF13852</td>
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</tr>
<tr>
<td></td>
<td>FYI: How cost sharing works with Blue Care Network plans</td>
<td>CF14832</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FYI: Take control of your health. Take the Blue Cross® Health &amp; Wellness online health assessment</td>
<td>CF9461</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FYI: How we coordinate Blue Care Network health coverage with your car or motorcycle insurer</td>
<td>CF13364</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Outpatient rehabilitation (one-page flier)</td>
<td>CF9003</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Understanding emergency procedures (one-page flier)</td>
<td>CF5693</td>
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<td></td>
<td>FYI: Understanding the referral process (one-page flier)</td>
<td>CF5694</td>
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<tr>
<td></td>
<td>FYI: Understanding your Blue Care Network coverage for therapy and physical medicine services</td>
<td>CF14835</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Woman’s Choice program (one-page flier)</td>
<td>CB10255</td>
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<tr>
<td></td>
<td>FYI: Your BCN drug benefits (one-page flier)</td>
<td>CF9004</td>
<td></td>
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<tr>
<td></td>
<td>FYI: Your primary care physician (one-page flier)</td>
<td>CF5695</td>
<td></td>
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<tr>
<td></td>
<td>&quot;Good Health&quot; (member magazine)</td>
<td>CF2865</td>
<td></td>
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<tr>
<td></td>
<td>Mail order pharmacy (brochure and envelope)</td>
<td>CK191</td>
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</tr>
<tr>
<td></td>
<td>Making the switch to Blue Care Network’s drug benefit (brochure)</td>
<td>CB11941</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCP Focus: Health care centered around you (two-sided flier)</td>
<td>CF12090</td>
<td></td>
</tr>
<tr>
<td>Group publications</td>
<td>FYI: Your online workplace wellness toolkit (one-page flier)</td>
<td>CF11052</td>
<td></td>
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<tr>
<td></td>
<td>HBL qualification form (form)</td>
<td>CN9454</td>
<td></td>
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<tr>
<td></td>
<td>Healthy Blue Living Products: Administrative guidelines (brochure)</td>
<td>CB11343</td>
<td></td>
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<tr>
<td>Member publications</td>
<td>Good Health: Healthy Blue Living (member magazine)</td>
<td>CF10854</td>
<td></td>
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<tr>
<td></td>
<td>Healthy Blue Living brochure: A health plan working for you</td>
<td>CB9440</td>
<td></td>
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<tr>
<td></td>
<td>Healthy Blue Living member guide (brochure)</td>
<td>CB9459</td>
<td></td>
</tr>
</tbody>
</table>

If you need a form that's not on this list, please call Field Services at 1-877-465-5120.
To order open enrollment or new hire kits, contact your sales representative or independent agent.
To mail, send to: Publications — C103, Blue Care Network, P.O. Box 5043, Southfield, MI 48066-5043.
Customer Service

Answering member questions

Customer Service representatives can help members with the following:

- Benefit questions
- Address changes
- Eligibility inquiries
- ID card requests
- Complaints or grievances
- Quality-related service issues
- Claims issues

Contact

- The regular Customer Service telephone number is 1-800-662-6667.
- For the hearing impaired, call TTY at 711.
- Representatives are available from 8 a.m. to 5:30 p.m. Monday through Friday.

Customer service Monday through Friday 8:30 a.m. to 4:45 p.m.

- **Ann Arbor (walk-in service)**
  2311 Green Road, Suite 2323
- **Flint (hotline telephone service)**
  4520 Linden Creek Parkway, Suite A
- **Grand Rapids (hotline telephone service)**
  611 Cascade West Parkway, SE
- **Jackson (hotline telephone service)**
  1000 N. Wisner, Suite 5 (in the Wisner Plaza Mall)
- **Southfield corporate headquarters (walk-in service)**
  20500 Civic Center Drive
Member Information

Blue Cross health and wellness
Our Blue Cross Health & Wellness programs help members get healthy, stay well and manage illness by offering health education, chronic condition management and support programs tailored to your needs.

Chronic condition management programs  1-800-392-4247
BCN has comprehensive programs to help members manage asthma, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, heart failure, kidney disease, low back pain and migraine headaches.

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

Tobacco Cessation Coaching program  1-855-326-5102
BCN’s smoking cessation program offers members a battery of tools to help them quit smoking, including the opportunity to talk to a registered nurse about how to kick the habit.

Online information
Our Web site, bcbsm.com, is a valuable resource, providing a variety of health information that can help members get the most from their coverage. Here’s some of what members can do online:

- Complete a health assessment and develop a personal action plan
- Verify eligibility for everyone on the subscriber’s contract
- Order ID cards
- View and print claim summaries
- View benefits (certificates and riders)
- Change primary care physician
- Research and compare doctors, investigate hospital quality and explore medical and drug treatments
- Save on healthy goods and services from Michigan-based companies by visiting Member Discounts with Blue365® at bcbsm.com