Blue Care Network
Certificate of Coverage
BCN Classic HMO
for Self-Funded Large Groups

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

This certificate contains information about the benefits offered under your employee welfare benefit plan. Because we are an independent corporation licensed by the Blue Cross and Blue Shield Association ("BCBSA") – an association of independent Blue Cross and Blue Shield plans – we are allowed to use the Blue Cross and Blue Shield names and service marks in the state of Michigan. However, we are not an agent of the BCBSA and, by accepting this certificate, you and your employer agree that this certificate is based only on what you and your employer were told by BCN or its agents. Only BCN and your employer have an obligation to provide benefits under this certificate and no other obligations are created or implied by this language.

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

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

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

Your employer offers this Coverage. Your eligibility and Benefits are subject to the contract made between your employer and BCN.

The Group Health Plan is self-funded, which means that the Benefits are paid from the Group funds and are not provided through an insurance contract. Blue Care Network ("BCN") administers the benefit plan for your employer and provides administrative claims payment services only. BCN does not insure the coverage nor do we assume any financial risk or obligation with respect to claims.

The Benefits offered under your Coverage are in accordance with the Administrative Services Contract ("ASC").

The Certificate of Coverage and any attached Riders, along with any booklets and/or guidelines provided by the Group, or eligibility and enrollment policies maintained by the Group serve as the Group Health Plan document. Please read these documents carefully and keep them with your personal records for future reference.

The Group reserves the right to interpret and resolve conflicts between any statements in the Certificate of Coverage and attached Riders that conflict with the Group's booklets, summaries or other benefit related documents.

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

Blue Care Network
20500 Civic Center Drive
Southfield, MI 48076
800-662-6667
https://www.bcbsm.com/

Definitions

These definitions will help you understand the terms that we use in this Certificate. They apply to the entire Certificate. More terms are defined in later sections as necessary. In addition to these terms, use of the terms "we", "us" and "our" refer to BCN or another entity or person BCN authorizes to act on its behalf. The terms "you" or "your" refer to the Member, who is enrolled with BCN as either a Subscriber or Family Dependent.

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

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

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

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

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

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

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

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

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

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

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

Coinsurance is your share of the costs of a Covered Service calculated as a percentage of the BCN Approved Amount that you owe after you pay any Deductible. This amount is determined

based on the Approved Amount at the time the claims are processed or reprocessed. Your Coinsurance is not altered by an audit or recovery. Your Coinsurance is added or amended when a Rider is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

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

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

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

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

Covered Services or Coverage refers to those Medically Necessary services, drugs, or supplies provided in accordance with and identified as payable under the terms of the Certificate. The services must be ordered or performed by a BCN Participating Provider that is legally authorized or licensed to order or perform the service.

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

Deductible is the amount that you owe for health care services before we pay. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed or reprocessed. Your Deductible is not altered by an audit or recovery. Your Deductible amount is added or amended when a Rider is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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

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

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

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

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

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

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

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

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

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

Group Health Plan means the benefits plan provided by your Group.

Hospital is a Facility that is fully licensed and certified as required by law and complies with all applicable national certification and accreditation standards. This Facility provides continuous, 24-hour inpatient medical, surgical or obstetrical care and outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons. Hospital Services are provided by or under the supervision of a professional staff of licensed physicians, surgeons, and registered nurses. The term "Hospital" does not include a Facility that is primarily a nursing care Facility, rest home, home for the aged or a Facility primarily to treat substance use disorder, psychiatric disorders or pulmonary tuberculosis.

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

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

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

Medical Necessity or Medically Necessary Services are health care Services provided to a Member according to evidence-based clinical practice guidelines (proven to be safe and effective based on current research) for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are:

- Rendered in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease or its symptoms
- Not primarily for the convenience of the Member or health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease
- Not regarded as experimental by BCN
- Rendered in accordance with BCN Utilization Management Criteria

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

Mental Health Provider is duly licensed and qualified to provide Mental Health Services in a Hospital or other Facility in the state where treatment is received.

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

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

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

Open Enrollment Period is a period of time set each year when eligible people may enroll or dis-enroll in BCN.

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

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

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

PCP Referral is the process by which the Primary Care Physician (PCP) directs your care to a Referral Physician (Specialist) prior to a specified Service or treatment plan. The PCP must coordinate the Referral and any necessary BCN Preauthorization.

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

Premium is the amount that must be paid for health care Coverage. Your employer usually pays it monthly based on its contract with BCN. This amount may include employee contributions.

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

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

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Principally Supported Child is an individual less than 26 years of age for whom principal financial support is provided by the Subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for Coverage. A Principally Supported Child must meet the requirements stated in Section 1. **NOTE:** A Principally Supported Child is not the same as a Dependent Child.

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

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

Referral is a recommendation by your PCP for you to receive specialized care from a specialist or a Facility.

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

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

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

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

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

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

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

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

Skilled Nursing Facility is a state-licensed and certified subacute inpatient medical treatment center that provides continuous skilled care, rehabilitation services, and other health care Services by or under the supervision of a physician and a registered nurse. These health-related services in this Facility are provided to Members who do not require hospitalization, but are in need of skilled nursing care and the necessary equipment to provide the treatment needed for the Member's level of care.

Skilled care services must be:

- Performed by qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists, and speech pathologists. The services must be provided directly by or under the general supervision of these Skilled Nursing or Skilled Rehabilitation personnel to assure the safety of the Member and to achieve medically desired results
- Ordered by the attending physician
- Medically Necessary according to generally accepted medical standards
    - Examples include but are not limited to -
        - intravenous medication (including administration)
        - complex wound care

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

Subscriber is the eligible person who has enrolled for health care Coverage with BCN. This person's employment is the basis for Coverage eligibility. This person is also referred to as the "Member". **NOTE:** See Section 1 for eligibility requirements.

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

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

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

Your Benefits is Chapter 2. It describes your health care Coverage including exclusions and limitations.

Table of Contents

Chapter 1 — GENERAL PROVISIONS

Section 1: Eligibility, Enrollment, and Effective Date of Coverage

This section describes eligibility, enrollment and effective date of Coverage.
You must meet eligibility requirements set by the Group and BCN. Certain requirements depend on whether you are one of the following:

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

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

1.1 Group Subscribers

Eligibility

You must do all of the following:

1. Live in the BCN Service Area at least nine (9) months out of the Calendar Year
2. Be an active employee or eligible retiree of a Group
3. Meet the Group's eligibility requirement

Enrollment

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

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

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

Effective Date

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

1.2 Family Dependent

Eligibility

A Family Dependent is:

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

NOTE: Newborn children, including grandchildren, must be added to your contract to qualify for Coverage. Once added within the allowed eligibility timeframes, coverage will take effect from the date of birth.

- A Dependent under a Qualified Medical Child Support Order

Dependent Children and a Dependent under a Qualified Medical Child Support Order are eligible for Coverage until they turn 26 years of age. The child's BCN membership terminates at the end of the Calendar Year in which they turn 26.

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

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

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

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

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

Enrollment

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

- During the annual Open Enrollment Period
- When the Subscriber enrolls
- Within 31 days of a "qualifying event," that is, birth, marriage, placement for adoption, qualified medical child support order or foster care placement. **NOTE:** See below for additional requirements for Dependents under a Qualified Medical Child Support Order.
- Adopted children are eligible for health care Coverage from the date of placement

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

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

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

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

- Coverage is effective on the date of the qualifying event, if the Family Dependent is enrolled within 31 days of the event.
- If the Family Dependent is not enrolled within 31 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- For a Family Dependent who lost coverage and notifies BCN within 31 days, Coverage will be effective when the previous coverage lapses. If you do not notify BCN within 31 days, Coverage will not begin until the next Open Enrollment Period's effective date.
- Adopted children are eligible for Coverage from the date of placement.

1.3 Dependent under a Qualified Medical Child Support Order

Eligibility

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

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

Enrollment

The child may be enrolled at any time, preferably within 31 days of the court order. In addition:

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

Effective Date of Coverage

- If BCN receives notice within 31 days of the court or administrative order, Coverage is effective as of the date of the order.
- If BCN receives notice longer than 31 days after the order is issued, Coverage is effective on the date BCN receives notice.

1.4 Principally Supported Child

Eligibility

A Principally Supported Child must:

- Not be the child of the Subscriber or spouse by birth, legal adoption or legal guardianship
- Be related to the Subscriber by blood or marriage (for example, grandchild, niece or nephew)
- Be less than 26 years old
- Be unmarried
- Live full-time in the home with the Subscriber
- Not be eligible for Medicare or other group Coverage
- Be dependent on the Subscriber for principal financial support in accordance with Internal Revenue Service standards, and have met these standards for at least six (6) full months prior to applying for Coverage

Enrollment

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

To apply, you must furnish:

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

Effective Date of Coverage

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

1.5 Additional Eligibility Guidelines

The following guidelines apply to all Members:

- **Medicare**: If you become eligible to enroll in Medicare, you are eligible to enroll in only the applicable Medicare program except when Medicare is secondary payer by law.

  NOTE: If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this Certificate. This Certificate is not a Medicare Certificate. It is not intended to fill the gaps in Medicare Coverage and it may duplicate some Medicare benefits. If you are eligible for Medicare, you will need to switch to an applicable BCN Medicare plan. If this Certificate is maintained, you will be responsible for the cost Medicare would have paid and you will incur larger out of pocket costs.

- **Service Area Waiver**: Under certain circumstances, we may waive the Service Area requirement for a Subscriber or other Member on the Contract that lives outside the Service Area. Any waiver may be requested in writing.

- **Change of Status**: You agree to notify us within 31 days of any change in eligibility status of you or any Members on the Contract. When you are no longer eligible for Coverage, you are responsible for payment for any Services or Benefits.
- We only pay for Covered Services you receive when you are a BCN Member covered under this Certificate. If you are admitted to a Hospital or Skilled Nursing Facility either when you become a Member or when your BCN membership ends, BCN will only pay for Covered Services provided during the time you were a Member.

Section 2: Other Party Liability

IMPORTANT **NOTICE**

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

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

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

2.1 Non-Duplication

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

2.2 Auto Policy and Workers' Compensation Claims

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

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

- If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member's medical

services. BCN would provide for Covered Services under this Certificate as the secondary plan.

- If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. BCN would pay for Covered Services under this Certificate as the secondary plan.
- If the motorcycle insurance does not provide medical coverage or if that medical coverage is exhausted, then BCN will pay for Covered Services under this Certificate as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCN will pay secondary.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers' compensation law or program will not be paid by BCN.
- If any such services are paid or provided by BCN, BCN has the right to seek reimbursement from the other program, insurer or Member who has received reimbursement.
- Applicable BCN Preauthorization and Coverage requirements (i.e. seeking services from a Participating Provider except for Emergent situations) must always be followed for auto or work-related injuries. Failure to follow applicable Preauthorization and or Coverage requirements may leave you solely responsible for the cost of any services received.

2.3 Coordination of Benefits

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

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

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

2.4 Subrogation and Reimbursement

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

Your Responsibilities

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

- You assign to us your right to recover what BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a Lien or Right of Recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.

- You agree to inform BCN when your medical expenses should have been paid by another party but were not due to some act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your attorney of BCN rights and your obligations under this Certificate.
- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining written consent from BCN if the settlement relates to Services paid by BCN.
- You agree to cooperate with BCN in our efforts to recover money we paid on your behalf.
- You acknowledge and agree that this Certificate supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.
- You acknowledge and agree that this Certificate is a contract between you and BCN and any failure by you, other Members on the Contract or representatives to follow the terms of this Certificate will be a material breach of your contract with us.
    a. When you accept a BCN ID card for Coverage, you agree that, as a condition of receiving Benefits and Services under this Certificate, you will make every effort to recover funds from the liable party.
    b. When you accept a BCN ID card for Coverage, it is understood that you acknowledge BCN's right of subrogation. If BCN requests, you will authorize this action through a subrogation agreement. If a lawsuit by you or by BCN results in a financial recovery greater than the Services and Benefits provided by BCN, BCN has the right to recover its legal fees and costs out of the excess.
    c. When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and BCN, the costs and legal expenses will be divided equitably.
    d. You agree not to compromise, settle a claim, or take any action that would prejudice the rights and interests of BCN without getting BCN's prior written consent.
    e. If you refuse or do not cooperate with BCN regarding subrogation, it will be grounds for terminating membership in BCN upon 30 days written advance notice. BCN will have the right to recover from you the value of Services and Benefits provided to you.

Section 3: Member Rights and Responsibilities

3.1 Confidentiality of Health Care Records

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

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

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

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

3.2 Inspection of Medical Records

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

3.3 Primary Care Physician (PCP)

BCN requires you to choose a Primary Care Physician (PCP). You have the right to designate any PCP who is a Participating physician and who is able to accept you or your family members. If you do not choose a PCP upon enrollment, BCN will choose one for you.

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

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

Information on how to select a PCP, and a list of PCPs, Participating pediatricians and Participating health care professionals (including Certified Nurse Midwives) who specialize in obstetrics or gynecology is available at https://www.bcbsm.com/. You can also call Customer Service at the number shown on the back of your BCN ID card.

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

3.4 Grievance Procedure

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

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

Definitions:

Adverse Benefit Determination - means any of the following:

- A request for a benefit, on application of any utilization review technique, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination of a covered person's eligibility for coverage.
- A determination that Surprise Billing protections are not applicable or the improper application of those protections, including the calculation of the applicable cost-share.
- A prospective or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- A rescission of coverage determination
- Failure to respond in a timely manner to request for a determination

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

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

Step One

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

Appeals and Grievance Unit
Blue Care Network
P. O. Box 284
Southfield, MI 48086-5043
Fax 866-522-7345

The Appeals and Grievance Unit will review your concern and reply within 15 calendar days for Pre-Service Grievances and 30 calendar days for Post-Service Grievances.

The individuals who review the first-level grievance are not the same individuals involved in the initial decision. If your grievance is denied, BCN will send you a written explanation of the reasons for denial and the next steps in the process. If the grievance is about a clinical issue, we'll send it for review to an independent medical consultant in the same or similar specialty as the doctor who provided the service.

Step Two: Review by BCN Grievance Panel

If your grievance is denied, you may request review by BCN's Grievance Panel. You must file the request within 180 calendar days of receiving the adverse step one decision. For pre-service requests, you'll be notified of the step two grievance decision within 15 calendar days. For post-service requests, you'll be notified within 30 calendar days.

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

External Review by an Independent Review Organization

As a member enrolled in a self-funded ERISA group plan, you have the right to an external review by an independent review organization, or IRO. To appeal our decision, you must notify us in writing, and we'll randomly assign the review to one of our contracted IROs. The IRO decision is binding, and we'll be responsible for all costs incurred. You must exhaust this process before filing a lawsuit by:

Mail: Appeals and Grievance Unit, Blue Care Network
P.O. Box 284
Southfield, MI 48086
Fax: 1-866-522-7345

External Review by the Department of Insurance and Financial Services

If you're not a member of an ERISA group plan and don't agree with our decision at step two or if we're late in responding (add 10 business days if we ask for additional medical information), you'll be considered to have exhausted the internal grievance process. At this point, you may request external review by the Department of Insurance and Financial Services. You must send your external review request no later than 127 calendar days following receipt of our decision. Send to Appeals Section — Office of General Counsel, Department of Insurance and Financial Services by:

Mail:	**P.O. Box 30220** **Lansing, MI 48909-7720**
Personal delivery:	**530 W. Allegan Street, 7th floor** **Lansing, MI 48933-1070**
Phone:	**1-877-999-6442**
Fax:	**517-284-8838**
Online:	difs.state.mi.us/Complaints/ExternalReview.aspx (Blue Care Network doesn't control this website and isn't responsible for its content.)

Expedited review

Under certain circumstances – if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review – you can request an expedited review.

You, your doctor or someone acting on your behalf can initiate an expedited review by calling Customer Service number on the back of your BCN member ID card.

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

3.5 Additional Member Responsibilities

You have the responsibility to do the following:

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

3.6 Member's Role in Policy-Making

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

Section 4: Forms, Identification Cards, Records and Claims

4.1 Forms and Applications

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

You have the right to appeal our decision to Rescind your Coverage by following the Grievance procedure as described in Section 3 and online at https://www.bcbsm.com/importantinfo. To

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

4.2 Identification Card

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

To be entitled to Benefits, the person using the card must be the Member on whose behalf the Group or Group Health Plan have agreed to provide benefits. If the person is not entitled to receive Services, the person must pay for the Services received.

If you have not received your card or your card is lost or stolen, please contact Customer Service immediately by visiting https://www.bcbsm.com/. Information regarding how to obtain a new ID card is on our website.

4.3 Misuse of Identification Card

BCN may confiscate your BCN ID card and may terminate Coverage if you misuse it by doing any of the following:

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

4.4 Membership Records

- We maintain membership records.
- Benefits under this Certificate will not be available unless information is submitted in a satisfactory format by you or the Group.
- You are responsible for correcting any inaccurate information provided to BCN. If you intentionally fail to correct inaccurate information, you will be responsible to reimburse BCN for any Service paid based on the incorrect information.

4.5 Authorization to Receive Information

By accepting Coverage under this Certificate, you agree that:

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

4.6 Member Reimbursement

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

Additional information on how to submit a claim and the Reimbursement Form is available at https://www.bcbsm.com/. Send your itemized medical bills promptly to us.

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

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

Section 5: Termination of Coverage

5.1 Termination of Group Coverage

This Certificate and the contract between the Group and BCN will continue in effect for the period of time the Administrative Service Contract (ASC) remains in effect. The ASC and Coverage continue from year to year, subject to the rights of the Group, Group Health Plan and BCN to terminate the ASC. Coverage for Members will terminate on the date the ASC is terminated as permitted by law.

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

5.2 Termination for Nonpayment

Nonpayment by Group

- If a Group fails to reimburse BCN according to the terms of the ASC, BCN may terminate the ASC.
- If the ASC is terminated for nonpayment, any services received by Members after the date of termination and paid by BCN will be charged to the Member or, as permitted by law, to the Group.

Nonpayment History

BCN may decline renewal of any Member's coverage if the applicant or any Member on the contract has a history of delinquent payment of their share of the costs for Covered Services.

Nonpayment of Member's Cost Sharing

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

- You fail to pay applicable Cost Sharing or other fees within 90 days of their due date
- You do not make and comply with acceptable payment arrangements with the Participating Provider to correct the situation.

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

5.3 Termination of a Member's Coverage

Termination

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

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

Rescission

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

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

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

5.4 Extension of Benefits

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

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

- As noted in Section 1 Benefits are only provided when Members are eligible and covered under this Certificate. However, as permitted by law, this extension of Benefits will continue only for the condition being treated on the termination date, and only until **any one** of the following occurs:
    - You are discharged.
    - Your Benefit exhausted prior to the end of the contract.
    - You become eligible for other Coverage.

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

Section 6: Continuation Coverage

6.1 Loss Because of Eligibility Change

If you no longer meet eligibility requirements as described under Section 1, you may transfer to an alternate Benefit program offered by the Group, if any.

If no alternate Benefit program is available or if you are unable to meet any alternate Benefit program eligibility requirements, you may apply for non-group coverage through BCN or Blue Cross® Blue Shield® of Michigan.

To obtain information, you can call us at the number shown on the back of your BCN ID card.

6.2 COBRA Coverage

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

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

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

- You may apply and pay for group continuation coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
- This coverage may continue for up to 18, 29 or 36 months, depending on the reason for your initial ineligibility:
    a. You are considered a Group Member for all purposes including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
    b. Continuation coverage and all benefits cease automatically under any of the following

i. The period allowed by law expires

ii. The employer no longer includes BCN as part of its Group health plan

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

iv. You become eligible for Medicare

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

Section 7: Additional Provisions

7.1 Notice

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

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

7.2 Change of Address

You must notify your Group Health Plan and BCN immediately if your address changes. Except as otherwise stated in this Certificate, you must live within the Service Area for at 9 months out of each Calendar Year. (See Section 1)

7.3 Headings

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

7.4 Governing Law

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

7.5 Execution of Contract Coverage

By accepting any Benefit under this Certificate, you indicate your agreement to all terms, conditions and provisions of Coverage as described in this Certificate.

7.6 Assignment

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

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

7.7 Policies

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

7.8 Time Limit for Legal Action

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

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

7.9 Your Contract

Your contract consists of the following:

- Certificate of Coverage
- The contract between the Group and BCN
- Any attached Riders
- Your Member Handbook
- Your application signed by the Subscriber
- The BCN Identification card

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

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

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

7.10 Reliance on Verbal Communication and Waiver by Agents

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

No agent or any other person, except individuals designated by the Group Health Plan have the authority to do either of the following:

- Waive any conditions or restrictions of this Certificate; or

- Extend the time for making payment

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

7.11 Amendments

Coverage is subject to amendment, modification or termination in accordance with the terms of the Group Health Plan.

Such changes must be made in accordance with the terms of the ASC or by mutual agreement between the Group, Group Health Plan and BCN.

7.12 Major Disasters

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

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

Such circumstances include, but are not limited to:

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

7.13 Obtaining Additional Information

The following information is available:

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

You can obtain the information through these sources:

- Online at https://www.bcbsm.com/

- By writing BCN Customer Service at P.O. Box 68767, Grand Rapids, MI 49516-8767
- By calling our Customer Service Department at the number shown on the back of your BCN ID card
- By checking your BCN Welcome book

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

7.14 Right to Interpret Contract

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

7.15 Independent Contactors

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

7.16 Clerical Errors

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

7.17 Waiver

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

7.18 Unlicensed and Unauthorized Providers

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

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

7.19 Special Programs

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

We may terminate any special program based on:

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

7.20 Surprise Billing

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

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

7.21 BlueCard® Program

If you receive Covered Services in another state, the claims will be processed through the BlueCard® Program. This Addendum explains how it works. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

Out-of-Area Services

Overview

Blue Care Network ("BCN") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you, the Member, access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from providers in the Host Blue geographic area that do not have

a contractual agreement ("nonparticipating providers") with the Host Blue. BCN remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

BCN covers only limited healthcare services received outside of our Service Area. As used in this section "Out-of-Area Covered Healthcare Services" include, emergency care, urgent care, routine care and/or follow-up care obtained outside the geographic area we serve, subject to BCN coverage and authorization rules. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless Preauthorized by your Primary Care Physician ("PCP") or BCN.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCN to provide the specific service or services.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when you access Out-of-Area Covered Healthcare Services outside the BCN Service Area, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program will be based on the lower of the providers billed charges for Out-of-Area Covered Healthcare Services or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCN by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse

recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Out-of-Area Covered Healthcare Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

B. Nonparticipating Providers Outside of the BCN Service Area

1. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of the BCN Service Area by nonparticipating providers, the amount(s) you pay for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCN will make for Out-of-Area Covered Healthcare Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

2. Exceptions

In some exception cases, BCN may pay claims from nonparticipating providers for Out-of-Area Covered Healthcare Services based on the provider's billed charge. This may occur in situations where you did not have reasonable access to a participating provider, as determined by BCN and in accordance with applicable state law. In other exception cases, BCN may pay such a claim based on the payment BCN would make if BCN were paying a nonparticipating provider for the same Covered Healthcare Services inside of BCN Service Area, as described elsewhere in this contract. This may occur where the Host Blue's corresponding payment would be more than BCN in-Service Area nonparticipating provider payment. BCN may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCN will make for the covered services as set forth in this paragraph.

C. Blue Cross Blue Shield Global® Core

General Information

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Healthcare Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient hospital services, except for any cost sharing you may owe. In such cases, the Blue Cross Blue Shield Global® Core contracting hospital will submit your claims to the service center to initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for Covered Services. **You must contact us to obtain Preauthorization for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Healthcare Services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. The claim form is available from BCN, the service center or online at https://bcbsglobalcore.com. If you need assistance with the claim submissions, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

D. Exclusions and Limitations

This addendum will not apply if:

- the services are not a benefit under your Certificate of Coverage;
- the services are performed by a vendor or provider who has a contract with BCN for those services.

E. General Information

- If you have a Deductible, you will be responsible for payment of applicable Deductible for covered services at the time those services are received.
- Your Deductible, Coinsurance and Copayment requirements are based on your Certificate and Riders and remain the same regardless of which Host Blue processes your claim for services.

Chapter 2 – YOUR BENEFITS

Important Information

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

- Your health care benefits are provided as part of the Group Health Plan. BCN has contracted with the Group and Group Health Plan to administer your Coverage.

- As discussed in the Introduction of this Certificate, BCN will provide administrative services to support your Coverage, including customer service and responsibility for Preauthorizations for Services.

- The Services listed in this chapter are covered when Services are provided in accordance with Certificate requirements (including Referral from PCP or other Participating Provider) and, when required, are Preauthorized or approved by BCN except in an Emergency.

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

- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to:

  – Review of the diagnosis reported
  – Verification of Medical Necessity
  – Availability of Benefits at the time the claim is processed
  – Conditions, limitations, exclusions, maximums
  – Coinsurance, Copayments and Deductible under your Certificate and Riders

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

- Your PCP or other Participating Provider must coordinate Referrals and Pre-authorizations. You cannot self-refer unless specified in this Certificate.

- BCN maintains an extensive network of Participating Providers to assure that all Covered Services will be available to you without unreasonable delay. Our directory of Participating Providers is updated on an ongoing basis and published on Our website at https://www.bcbsm.com/. Please refer to the directory to ensure you are receiving services from Participating providers and avoiding any unnecessary costs to you.
- If there is an insufficient number of Participating Providers for a specific provider specialty within the BCN Service Area, you may obtain care from a Non-Participating provider when referred by your PCP and Preauthorized or approved by BCN. If Prior Authorization is not received before you receive Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for the full cost of the service when received

from a Non-Participating Provider.

- If you purchase a deluxe item or equipment when not Medically Necessary, the Approved Amount for the basic item applies toward the price of the deluxe item. You are responsible for any costs over the Approved Amount.
- Coverage is subject to the limitations and exclusions listed in this Chapter.
- A Rider as adopted by your Group may be attached to this Certificate that revises or applies Copayments, Coinsurance, Deductible, Out-of-Pocket Maximum, and/or Benefit Maximums. When a Rider is attached to this Certificate, the Rider will take precedence.
- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.
- You can find information about other Benefits as listed below in your member account at https://www.bcbsm.com/.
  - Disease management
  - Prevention
  - Wellness
  - Care management services

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

Section 8: Your Benefits

8.1 Cost Sharing

NOTE: Your employer may have chosen Cost Sharing be applied to this Certificate. Cost Sharing is detailed in any Riders attached to this Certificate.

Deductible

Your Plan may have a Deductible. The Deductible, if any, is detailed in a Rider attached to this Certificate. The Deductible is the amount you must pay before BCN will pay for Covered Services.

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

Copayment (Copay)

You are responsible for fixed dollar Copays defined in this Certificate and any Riders issued to you. Copays count toward your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, you will not be responsible for Copays for the remainder of the Calendar Year.

Coinsurance with the exception

You have no Coinsurance under this Certificate of the Services listed below unless a Rider is issued to you that amends your Coverage and applies a Coinsurance to specific Services. Coinsurance counts toward your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, you will not be responsible for Coinsurance for the remainder of the Calendar Year.

Your Coinsurance is 50 percent (50%) of the Approved Amount for the following Services:

- Allergy Services excluding allergy injections
- Infertility counseling and treatment
- Sterilization of male reproductive organs
- Reduction mammoplasty and male mastectomy
- Durable Medical Equipment
- Diabetic supplies
- Prosthetics and Orthotic
- TMJ treatment
- Orthognathic surgery
- Weight reduction procedures

NOTE: A Rider attached to this Certificate may amend the 50% Coinsurance.

Cost Sharing = Deductible, Copayment and Coinsurance Calculation

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

Out-of-Pocket Maximum

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

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

- Any Premium or contributions paid toward the Premium do not apply to the Out-of-Pocket Maximum

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

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

NOTE: Your Out-of-Pocket Maximum amount is reflected in a Rider attached to this Certificate.

Benefit Maximum

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

Examples of Covered Services with a Benefit Maximum include but are not limited to:

- Medical rehabilitation
- Spinal manipulations
- Skilled nursing days

8.2 Medical Professional Physician Services

A) We cover the following Services in full unless amended by a Rider.

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

- Primary Care Physician
- BCN Participating OB/GYN
- Referral Physician
- Online Visit by a BCN Participating Provider to:
  - ✓ Diagnose a condition
  - ✓ Make treatment and consultation recommendations
  - ✓ Write a prescription, if appropriate
  - ✓ Provide other medical or health treatment

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

  If an office visit Copay Rider is attached, the PCP office visit Copay applies. The PCP Copay applies whether the Online Visit is performed by the PCP or Referral Physician. If your Benefits have a Deductible and it applies to PCP office visits, then it will also apply to Online Visits.
  Important: Online Visits through the BCN designated online vendor are not covered unless a Rider is attached to this Certificate.

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

Online Visit exclusions include but are not limited to:

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

NOTE: See Preventive and Early Detection Services and Outpatient Services sections for further information about office visits.

- **Eye Care** – treatment of medical conditions and diseases of the eye are covered when Services are referred by your Primary Care Physician and Preauthorized by BCN.

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

  NOTE: If an office visit Copayment Rider is attached, the office visit Copay does not apply to routine prenatal and postnatal visits. The Copay does apply to non-routine (non-preventive) high risk prenatal visits.

- **Home Visits** by a physician in the home or temporary residence

  NOTE: For Home Health Care Services other than physician visit, please see the Home Health Care Services section in this chapter.

- **Inpatient Professional Services** while you are in an Inpatient Hospital or Skilled Nursing Facility, Inpatient Rehabilitation center, or Inpatient Hospital at Home admission and billed by a physician when Preauthorized by BCN

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

Coverage

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

- Mechanical traction once per day is covered when it is performed with chiropractic spinal manipulation.
- Radiological Services and X-rays are covered when Preauthorized.

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

Benefit Maximum

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

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

B) The following service applies Cost Sharing

Allergy Care — Allergy testing, evaluation, serum, injection of allergy serum and related office visits

Cost Sharing

50% Coinsurance of the Approved Amount for testing, evaluation, serum and related office visits

$5 Copay per visit for allergy injections

8.3 Continuity of Care for Professional and Facility Services

Continuity of Care for Existing Members

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

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

Provider Requirements

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

- Notifies BCN of their agreement that you qualify as a continuing care patient
- Continues to accept the Approved Amount as payment in full for the Services provided as if the provider's contract had not changed
- Continues to meet BCN's quality standards
- Continues to adhere to BCN medical and quality management policies and procedures;
- Provides up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider.

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

Complex Medical Conditions

Through Continuity of Care, you may continue your treatment if the following circumstances apply to you:

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

Determined to be terminally ill (defined as "a medical prognosis that the individual's life expectancy is six months or less") and is receiving treatment for this illness

Coverage

If the former Participating Provider (including your Primary Care Physician) agrees you are a continuing care patient and meets the "Provider Requirements" listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment for Medical Conditions detailed above. In order for additional Covered Services to be paid, your Participating Primary Care Physician must provide or coordinate all such Services.

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

Continuity of Care for New Members

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

You have up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider.

Complex Medical Conditions
Through Continuity of Care, you may continue your treatment if the following circumstances apply to you.

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

Determined to be terminally ill (defined as "a medical prognosis that the individual's life expectancy is six months or less") and is receiving treatment for this illness

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

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

8.4 Preventive and Early Detection Services

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

Preventive Services include but are not limited to the following:

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

Health screenings include but are not limited to the following.

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

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

- Gynecological (well woman) examinations including routine pap smear and mammography screening
- Screening for sexually transmitted diseases; HIV counseling and screening
- Contraceptive counseling and methods as required by PPACA and consistent with HRSA-Supported Women's Preventive Services Guidelines. FDA approved contraceptive methods include:
    - Contraceptive devices and appliances; such as intrauterine devices (IUDs);
    - Implantable and injected drugs such as Depo-Provera; and diaphragms including measurement, fittings, removal and administration and management of contraceptive care
    - Contraceptive mobile app; one annual membership (12 consecutive months) per Member
        - When you purchase a yearly subscription for an FDA-approved contraceptive mobile app, log into your Member account at https://www.bcbsm.com/ to find and fill out a reimbursement form. Submit the form along with your receipt for reimbursement. BCN will reimburse you up to charge for your yearly subscription.

- Routine preventive prenatal and postnatal office visits
- Maternity counseling for the promotion and support of breast-feeding, prenatal vitamin counseling, and alternative fertility awareness methods
- Breast pump and associated supplies needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. (See Durable Medical Equipment section for limitations and exclusions)
- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening
- Screening for gestational diabetes
- Bone Density screening
- Genetic counseling and BRCA testing if appropriate for Member's whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes
- Screening and counseling for interpersonal and domestic violence
- Sterilization procedures for Members with female reproductive organs such as tubal ligation and related charges associated with the procedure (anesthesia, labs, ect.)

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

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

E) **Nutritional counseling** including Diabetes Self-Management, and diet behavioral counseling. Other nutritional counseling Services may be covered when Preauthorized by BCN.

NOTE: Certain health education and health counseling Services may be arranged through your Primary Care Physician, but are not payable under your Certificate. Examples include but are not limited to:

- Lactation classes not provided by your physician
- Tobacco cessation programs (other than a BCN tobacco cessation program)
- Exercise classes

F) **Routine cancer screenings** including but not limited to:

- Colonoscopy
- Flexible sigmoidoscopy
- Prostate (PSA/DRE) screenings

For the purposes of this Certificate, "**Routine**" means non-urgent, non- emergent, non-symptomatic medical care provided for the purpose of disease prevention.

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

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

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

J) A and B rated preventive medications as recommended by the U.S. Preventive Services Task Force (USPSTF)

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

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

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

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

8.5 Inpatient Hospital (Facility) Services

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

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

  Under federal law, the gestational parent is covered for no less than the following length of stay in a hospital in connection with childbirth except as excluded under Section 9.

  – 48 hours following a vaginal delivery

  – 96 hours following a delivery by cesarean section

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

- Newborn care

  Under federal law, the newborn child is covered for no less than the following length of stay in a hospital in connection with childbirth except as excluded under Section 9.

  – 48 hours following a vaginal delivery

  – 96 hours following a delivery by cesarean section

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

The baby must be eligible for coverage and must be added to your contract within the eligibility timeframe set by the Group.

Newborn care includes:

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

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

See section 8.2 for Inpatient Professional Services for Cost Sharing.

8.6 Outpatient Services

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

You receive Outpatient Services in these places:

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

Outpatient Services include but are not limited to:

- Facility and professional (physician) Services
- Surgical treatment
- Anesthesia, laboratory, X-rays, radiology and pathology Services
- Chemotherapy, inhalation therapy, radiation therapy and dialysis
- Physical, speech and occupational therapy - see Outpatient Therapy Services
- Injections (for allergy) – see Medical Professional Physician Services section
- Professional Services – see Medical Professional Physician Services section
- Durable Medical Equipment and supplies - see Durable Medical Equipment section
- Diabetic equipment and supplies - see Diabetic Supplies and Equipment section
- Prosthetic and Orthotic equipment and supplies - see Prosthetic and Orthotics section

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

8.7 Emergency and Urgent Care

Definitions

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

Emergency Services - Services to treat a Medical Emergency as described below:

Medical Emergency – Whether a condition is a "Medical Emergency" does not depend on a particular diagnosis. Instead, it is based on the sudden onset of a serious medical condition resulting from injury, sickness or behavioral health condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant Member, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

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

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

Coverage

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

In case of such Medical Emergency or Accidental Injury, you should seek treatment at once. We urge you, the Hospital or someone acting on your behalf to notify your Primary Care Physician or BCN within 24 hours, or as soon as medically reasonable. Admission to the hospital after a Medical Emergency has been stabilized requires Authorization by BCN. However, Prior Authorization is not required for you to obtain Emergency Services.

Emergency Services include professional and related ancillary Services and Emergency Services provided in an Urgent Care Center or Hospital Emergency room or independent freestanding emergency departments. Emergency Services are covered regardless of whether the provider or Facility is Participating.

In Participating Hospitals and independent free standing emergency departments, Emergency Services are no longer payable as Emergency Services at the point of the Member's Stabilization as defined above. In Non-Participating Hospitals and independent free standing emergency departments, services rendered after the Member is Stabilized will continue to be Emergency Services until the Member receives and signs a notice and consent form as required under the No Surprises Act.

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

If you are admitted as an Inpatient because of the Emergency, the Inpatient Hospital Benefit as described in this chapter and attached Riders will apply.

NOTE: Observation stay resulting from Emergency Services is subject to Emergency room Cost Sharing when a Rider is attached.

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

Admission to Non-Participating Hospital after Emergency Services

If you are hospitalized in a Non-Participating Hospital, we may require that you be transferred to a Participating Hospital as soon as you have Stabilized. If you refuse to be transferred, you may be required to sign a notice and consent form by the Non-Participating Hospital to continue receiving services. If you sign this form, all related non-Emergency Covered Services will not be covered from the date when the form is signed.

Out-of-Area and Non-Participating Provider Coverage

You are covered when traveling within or outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above. (See Section 7.21 BlueCard® Program for additional information.)

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

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

8.8 Ambulance

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

For ground ambulance, a covered destination may include:

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

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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

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

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

Coverage also includes when:

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

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

Air ambulance
Air Ambulance services must also meet these requirements:

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

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

Exclusions include but are not limited to

- Transportation or medical Services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated Services provided as part of a response to an accident or Emergency situation, like accident clean-up or 911 costs are not a Covered Benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.

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

8.9 Reproductive Care and Family Planning

We cover reproductive care and family planning.

- Non-Elective Abortion
- Genetic Testing
- Voluntary Sterilization
- Infertility
- Fertility Preservation

A) Non-Elective Abortion

We cover a Non-Elective Abortion **only** on the following instances:

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

Cost Sharing

Your Inpatient and Outpatient Benefit applies to Non-Elective Abortion procedures including office consultations as defined in applicable Riders associated with your Plan.

Exclusions include but are not limited to

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

B) Genetic Testing

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

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

Exclusions include but are not limited to

- Genetic testing and counseling for non-Members

C) Voluntary Sterilization

We cover Inpatient; Outpatient and office based adult sterilization Services.

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

Cost Sharing

Sterilization of Male Reproductive Organs
50% Coinsurance of the Approved Amount of all fees associated with Facility, professional and related Services

The 50% Coinsurance applies toward your Out-of-Pocket Maximum

Exclusions include, but are not limited to

Reversal of surgical sterilization

D) Infertility

Coverage includes diagnosis, counseling and treatment of infertility when Medically Necessary and Preauthorized by BCN except as stated below and in Section 9. Following the initial sequence of diagnostic work-up and treatment, additional work-ups may begin only if Preauthorized by BCN.

Cost Sharing

50% Coinsurance of the Approved Amount for all fees associated with infertility diagnostic work-up procedures, treatment and all Facility professional and related Services, including prescription drugs

The 50% Coinsurance applies toward the Out-of-Pocket Maximum

Exclusions include but are not limited to

- Harvesting
- Storage or manipulation of eggs and sperm
- Services for the partner in a couple who is not enrolled with BCN and does not have Coverage for infertility Services or has other coverage
- In-vitro fertilization (IVF) procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related Services
- Artificial insemination (except for treatment of infertility)

- All Services related to surrogate parenting arrangements including, but not limited to, maternity and obstetrical care for non-member surrogate parents
- Reversal procedures and other infertility Services for couples who have undergone a prior voluntary sterilization procedure (e.g. vasectomy or tubal ligation)

E) Fertility Preservation

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

We cover the following procedures for fertility preservation:

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

Cost Sharing

Your Inpatient and Outpatient Cost Share applies to fertility preservation procedures including office consultations, diagnostic and surgical services as defined in applicable Riders associated with your plan.

Exclusions include but are not limited to:

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

8.10 Skilled Nursing Facility

We cover Skilled Nursing Facility Services for recovery from surgery, disease or injury when determined to be Medically Necessary and Preauthorized by BCN.

Benefit Maximum

Limited to a total Benefit Maximum of **45 days** per Calendar Year

Exclusions include but are not limited to

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

8.11 Hospice Care

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

Hospice Care in a Participating licensed hospice facility, hospital or Skilled Nursing Facility is covered. We cover hospice care in the home.

Hospice Care includes the following:

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

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

Exclusions include but are not limited to

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

8.12 Home Health Care Services

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

Home Health Care must be:

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

We cover the following Services:

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

  NOTE: Outpatient Therapy limits as defined in Outpatient Therapy Services section do not apply.
- Other health care Services approved by BCN when performed in the Member's home

Exclusions include but are not limited to

- Housekeeping services
- Custodial Care (See Section 9)

8.13 Home Infusion Therapy Services

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

Food Supplements

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

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

Coverage

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

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

A. Mental Health Care

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

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

Definitions

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

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

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program
- A structured environment that will allow the individual to reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the Member's usual living environment
- Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program").The treatment is managed by a multidisciplinary treatment team and reviewed regularly with the Member and team at least once weekly

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

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

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

Coverage

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

Cost Sharing

Inpatient Mental Health/Residential Mental Health/Partial Hospitalization

Your Inpatient/Residential Mental Health and Partial Hospitalization Coverage is the same as your medical Inpatient Benefit as defined in Riders associated with your plan including any applicable Cost-Sharing. Your Cost-Share applies to the Out-of-Pocket Maximum.

Outpatient Mental Health/Intensive Outpatient Mental Health

Your Outpatient Mental Health/Intensive Outpatient Mental Health office visit Coverage is the same as your Primary Care Physician office visit Copay as defined in your Office Visit Copayment Rider. You are required to pay your Copay at the time the Service is rendered, no matter the location including online visits.

If you have a Deductible Rider, you may be responsible for meeting the Deductible prior to BCN paying for Covered Services. Refer to your Deductible Rider for Covered Services that do not apply to your Deductible.

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

See Section 9 for Exclusions and Limitations.

B. Substance Use Disorder Services

Substance Use Disorder treatment means treatment for physiological or psychological dependence on or abuse of alcohol, drugs or other substances. Diagnosis and treatment may include medication therapy, psychotherapy, counseling, Detoxification Services, medical testing, diagnostic evaluation and Referral to other Services.

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

Medical Inpatient services required during a period of Substance Use Disorder admission must be authorized separately by your Primary Care Physician and BCN.

Definitions

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

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

Intermediate Care refers to Substance Use Disorder Services that have a residential (overnight) component. Intermediate Care includes Detox, Domiciliary Partial and residential (including "inpatient") services.

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

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

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

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

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

Coverage

Substance Use Disorder Services including counseling, medical testing, diagnostic evaluation and Detox are covered in a variety of settings. To obtain Preauthorization for Services call Behavioral Health Management at the number shown on the back of your BCN ID card. They are available 24 hours a day/7 days a week. You do not need a Referral from your Primary Care Physician to get care.

Cost Sharing

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

Your Detox/Residential/Intermediate Care/Partial Hospitalization/Partial Domiciliary Coverage is the same as your medical Inpatient Benefit as defined in Riders associated with your plan including any applicable Cost-Sharing. Your Cost Sharing applies to the Out-of-Pocket Maximum.

Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder

Your Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder Coverage is the same as your Primary Care Physician office visit Copay. This is reflected in your Office Visit Copayment Rider. You are required to pay your Copay at the time the service is rendered, no matter the location.

If you have a Deductible Rider, you may be responsible for meeting the Deductible prior to BCN paying for Covered Services. Refer to your Deductible Rider for Covered Services not applicable to the Deductible.

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

See Section 9 for Exclusions and Limitations.

8.15 Outpatient Therapy Services

Outpatient Therapy and/or Rehabilitative Services are Services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles including:

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

We cover s**hort-term Outpatient Therapy Services** when:

- Preauthorized by BCN as Medically Necessary
- Treatment for recovery from surgery, disease or injury
- Provided in an Outpatient setting
- Services are not provided by any federal or state agency or any local political subdivision, including school districts
- Results in meaningful improvement in your ability to do important day to day activities within 60 days of starting treatment

Benefit Maximum

Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies including medical rehabilitation, physical therapy, occupational therapy, speech therapy and mechanical traction.

Note: When two or more therapies are received on the same treatment day, each type of therapy counts as one visit. For example, if you have physical and occupational therapy on the same day, it counts as two visits against your limit.

General Exclusions include but are not limited to

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

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

Additional Exclusions for Speech Therapy include but are not limited to

- Speech therapy for neurodevelopmental disorders, including syntax, semantic or articulation disorders. This would include speech therapy for Member's with underlying conditions such as cerebral palsy or intellectual disability
- Maintenance of current speech level
- Sensory, behavioral, cognitive or attention disorders
- Treatment of stuttering or stammering
- Long-standing chronic conditions where improvement is unlikely.
- Learning disabilities
- Deviant swallow or tongue thrust
- Mild and moderate developmental speech or language disorders that are self-correcting and not severe
- Vocal cord abuse resulting from life-style or employment activities such as, but not limited to, cheerleading, coaching, and singing. Voice therapy, however, is covered in the presence of vocal cord nodules, polyps, or vocal cord paralysis
- Treatment for children who are eligible to receive speech therapy through school or a public agency

8.16 Durable Medical Equipment

Durable Medical Equipment (DME) must be:

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

Coverage

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

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

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

Cost Sharing

50% Coinsurance of the Approved Amount

The 50% Coinsurance applies toward the Out-of-Pocket Maximum.

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

Limitations and Exclusions

Limitations include but are not limited to

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

Exclusions include but are not limited to

- Deluxe equipment (such as motor-driven wheelchairs and beds, etc.) unless Medically Necessary for the Member or required so the Member can operate the equipment

  NOTE: If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the Approved Amount designated by BCN
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bed boards, bathtub lifts, overhead tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds)
- Physician's equipment (such as blood pressure cuffs and stethoscopes)
- Disposable supplies (such as sheets, bags, ear plugs, elastic stockings)
- Over the counter supplies including wound care(such as disposable dressing and wound care supplies) in absence of skilled nursing visits in the home
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills)

- Self-help devices that are not primarily medical items (such as sauna baths, elevators, ramps, special telephone or communication devices)
- Equipment that is experimental or for research (See Section 9)
- Needles and syringes for purposes other than for treatment of diabetes
- Repair or replacement due to loss, theft, damage or damage that can be repaired
- Assistive technology and adaptive equipment such as computers, supine boards, prone standers and gait trainers
- Modifications to your home, living area, or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, swimming pools and car seats
- All repairs and maintenance that result from misuse or abuse
- Any late fees or purchase fees if the rental equipment is not returned within the stipulated period of time

8.17 Diabetic Supplies and Equipment

Basic Diabetic Supplies and Equipment are used for the prevention and treatment of clinical diabetes.
Diabetic supplies must be:

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

We cover the following:

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

Diabetic Supplies and Equipment are limited to basic equipment. Special features must meet Medical Necessity criteria and may require Prior Authorization by BCN. Replacement of diabetic equipment is covered only when Medically Necessary.

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

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

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

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

Cost Sharing

50% Coinsurance of the Approved Amount

The 50% Coinsurance applies towards the Out-of-Pocket Maximum

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

Exclusions include but are not limited to

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

8.18 Prosthetics and Orthotics

Definitions

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

Prosthetic Devices are either:

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

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

Coverage

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

Coverage includes but is not limited to the following:

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

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

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

Cost Sharing

External Prosthetic Devices and Orthotics
50% Coinsurance of the Approved Amount

The 50% Coinsurance applies towards the Out-of-Pocket Maximum.

Internal Implantable Prosthetic Devices
Your Inpatient, Outpatient or office visit Benefit applies.
The Cost Sharing applies to the Out-of-Pocket Maximum.

Limitations

The item must meet the Coverage definition of a Prosthetic or Orthotic device and the following requirements.

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

Exclusions include but are not limited to

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

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

8.19 Organ and Tissue Transplants

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

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

Your Inpatient and Outpatient Cost Sharing applies as defined in the Riders attached to this Certificate.

Donor Coverage

Donor Coverage for a BCN Recipient

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

Donor Coverage for a non-BCN Recipient

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

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

Exclusions include but are not limited to

- Community wide searches for a donor

8.20 Reconstructive Surgery

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

Reconstructive Surgery includes the following:

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

We cover Reconstructive Surgery, as defined above, when it is Medically Necessary and Preauthorized by BCN. Your Inpatient or Outpatient Benefit applies.

Cost Sharing

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

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

The 50% Coinsurance applies toward the Out-of-Pocket Maximum.

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

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

The 50% Coinsurance applies toward the Out-of-Pocket Maximum.

8.21 Oral Surgery

We cover oral surgery and X-rays listed below when Medically Necessary and Preauthorized by BCN.

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

  NOTE: "Immediate" means treatment within 72 hours of the injury. Any follow-up treatment performed after the first 72 hours post-injury is not covered.
- Anesthesia in an Outpatient Facility setting when Medically Necessary and Preauthorized by BCN
- Surgery for removing tumors and cysts within the mouth

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

Exclusions include but are not limited to

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

See Section 9 for additional exclusions.

8.22 Temporomandibular Joint Syndrome (TMJ) Treatment

Definition

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

Coverage

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

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

Important: Dental Services are not covered.

Cost Sharing
50% Coinsurance of the Approved Amount of all fees associated with Facility, professional and related Services

The 50% Coinsurance applies to the Out-of-Pocket Maximum.

Exclusions include but are not limited to
- Dental and orthodontic services, treatment, prostheses and appliances for or related to TMJ treatment
- Dental X-rays
- Dental appliances including bite splints

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

Coverage
We cover the Services listed below when Medically Necessary and Preauthorized by BCN:
- Office consultation with Specialist Physician
- Cephalometric study and X-rays
- Orthognathic surgery
- Postoperative care
- Hospitalization – only when it is Medically Necessary to perform the surgery in a Hospital setting

Cost Sharing
50% Coinsurance of the Approved Amount of all fees associated with Facility, professional and related Services

The 50% Coinsurance applies toward the Out-of-Pocket Maximum.

Exclusions include but are not limited to
- Dental or orthodontic treatment (including braces)
- Prostheses and appliances for or related to treatment for orthognathic conditions

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

Cost Sharing
50% Coinsurance of the Approved Amount of all fees associated with Facility, professional and all related Services

The 50% Coinsurance applies to the Out-of-Pocket Maximum.

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

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

A) Prescription Drugs Received while you are an Inpatient

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

B) Cancer Drug Therapy

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

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

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

Cancer Drug Therapy – Covered in full
Cost of administration – Covered in full

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

C) Injectable Drugs

The following drugs are covered as medical Benefits:

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

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

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

Exclusions include but are not limited to

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

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

D) Outpatient Prescription Drugs

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

NOTE: See Preventive Services Section for a list of preventive drugs that are covered.

8.26 Clinical Trials

Definition

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

- A federally funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the FDA

- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Care Act

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

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

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

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

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

- The referring provider participated in the trials and has concluded that the Member's participation in it would be appropriate because the Member meets the trial's protocol
- The Member provides medical and scientific information establishing that the Member's participation in the trial would be appropriate because they meet the trial's protocol

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

- The investigational item, device or Service itself
- Items and Services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member

- A Service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Coverage

We cover the routine costs of items and Services related to Phase I, Phase II, Phase III and Phase IV Clinical Trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition.

Experimental treatment and Services related to the Experimental treatment are covered when all of the following are met:

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

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

Limitations and exclusions include but are not limited to

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

8.27 Gender Affirming Services

Definitions

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

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

Coverage

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

Cost Sharing

Your Inpatient and Outpatient Benefit Cost Sharing applies including office consultations as defined in the applicable Riders attached to this Certificate.

Exclusions include but are not limited to

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

Section 9: Exclusions and Limitations

This section lists many of the exclusions and limitations of your Coverage. Please refer to a specific Service in Section 8 and attached Riders for more exclusions and limitations.

9.1 Unauthorized and Out of Network Services

Except for Emergency care as specified in Section 8 and Chapter 2, Important Information Section, health, medical and hospital Services are covered **only** when:

- Provided by a Participating Provider
- Preauthorized by BCN for select Services

Current information regarding services that require Preauthorization is available by calling Customer Service at the number shown on the back of BCN ID card or visiting https://www.bcbsm.com/priorauth.

9.2 Services Received While a Member

We will only pay for Covered Services you receive while you are a Member and covered under this Certificate and attached Riders. Once your Coverage under this Certificate ends, any attached Riders to this Certificate will automatically end without further action or notice by BCN.

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

9.3 Services that are not Medically Necessary

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

9.4 Non-Covered Services

We do not pay for these Services:

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

- Autopsies
- Applied Behavioral Analysis for treatment of Autism Spectrum disorders (unless covered by a Rider).
- Employment related counseling
- Modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities;
- Fees incurred for collections, processing and storage of blood, cells, tissue, organs or other bodily parts in a family, private or public bank or other facility without immediate medical indication
- Testing to determine legal parentage
- Services performed by a provider with your same legal residence
- Services performed by a provider who is a family member
- Food, dietary supplements and metabolic foods
- Private duty nursing
- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
- Services outside the scope of practice of the servicing provider
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Late fees
- Psychoanalysis and psychotherapy that is not intended or likely to produce meaningful improvement
- Transitional living centers such as three-quarter house or half-way house, therapeutic boarding schools, domiciliary foster care and milieu therapies such as wilderness programs, other supportive housing, and group homes. These centers and programs are not considered residential treatment facilities.
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment
- Treatment programs that have predetermined or fixed lengths of care
- Inpatient hospital stays, when Acute Care as an inpatient is not necessitated by the Member's condition when safe and adequate care can be received as an outpatient or in a less intensified medical setting
- Court ordered examinations, tests, reports or treatments that do not meet requirements for Coverage (i.e., are not Medically Necessary) such as treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider

- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs like
    - Dance therapy
    - Art therapy
    - Equine therapy
    - Ropes courses
    - Music therapy
    - Yoga and other movement therapies
    - Guided imagery
    - Consciousness raising
    - Socialization therapy
    - Social outings and education/preparatory courses or classes

9.5 Cosmetic Surgery

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

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

- Elective rhinoplasty
- Spider vein repair
- Breast augmentation

We do not pay for any related service such as pre-surgical care, follow-up care and reversal or revision of surgery.

9.6 Prescription Drugs

We do not pay for the following drugs:

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

However, you may have a Prescription Drug Rider offered by your Group and added to your Coverage.

9.7 Military Care

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

9.8 Custodial Care

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

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

9.9 Comfort Items

We do not pay for comfort items:

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

9.10 Court Related Services

- We do not cover court ordered services including but not limited to pretrial and court testimony, court-ordered exams or the preparation of court-related reports that do not meet health care coverage requirements.
- We do not cover court-ordered treatment for substance use disorder or mental illness except when Services are Medically Necessary and meet the requirements specified in Section 8.
- We shall not be liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's engagement in an illegal occupation.

9.11 Elective Procedures

We do not pay for elective procedures:

- Reversal of a surgical sterilization
- All services, supplies and medications relating to Elective Abortions (unless covered by an applicable Rider)
- In vitro fertilization (IVF) procedures, such as GIFT-gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer and all related services
- Artificial insemination except for treatment of infertility
- Genetic testing and counseling for non-Members for any purpose.

9.12 Maternity Services

We do not pay for these maternity services:

- Lamaze, parenting or other similar classes
- Services and supplies provided by a lay-midwife for home births
- All services provided to non-member surrogate parents
- Services provided to the newborn if one of the following apply:
  - The newborn's gestational parent is not covered under this Certificate on the newborn's date of birth

- The newborn is covered under any other health care benefit plan on his or her date of birth
- When the newborn is not eligible and not added to the contract within the time stated in the eligibility section of the Certificate.
- The Subscriber directs BCN not to cover the newborn's services
- Services provided to the newborn occur after the 48 or 96 hours defined under the gestational parent's maternity care benefit

9.13 Dental Services

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

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

9.14 Services Covered Through Other Programs

We do not pay for services that are covered through other programs.

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or Certificate
- Under any other policy, program, contract or insurance as stated in General Provisions, Section 2 "Other Party Liability". (The General Provisions chapter describes the rules of your health care Coverage.)
- Under any public health care, school, or public program supported totally or partly by State, Federal or Local governmental funds, except where BCN is made primary by law
- The following are excluded to the extent permitted by law-
  - Services and supplies provided in a Non-Participating Hospital owned and operated by any Federal, State or other governmental entity
  - Services and supplies provided while in detention or incarcerated in a facility such as youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment
- Services and supplies provided under any contractual, employment or private arrangement, (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or hospital services
- Emergency Services paid by foreign government public health programs

- Any services whose costs are covered by third parties (including, but not limited to, employer paid services such as travel inoculations and services paid for by research sponsors)

9.15 Alternative Services

We do not pay for alternative services. Alternative treatments are not used in standard Western medicine. It is not widely taught in medical schools.

Services include but are not limited to:

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

We do not cover evaluations and office visits related to alternative services.

9.16 Vision Services

We do not pay for vision services:

- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Routine non-medically necessary vision and optometric exams
- Refractions, unless Medically Necessary
- Glasses, frames and contact lenses except as defined in Section 8
- Dilation
- Visual training or visual therapy for learning disabilities such as dyslexia

9.17 Hearing Aid Services

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

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

- Conformity evaluation test to verify receipt of the hearing aid, evaluate its comfort, function and effectiveness or adjustments to the hearing aid

9.18 Out of Area Services

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

Services received outside of Michigan are administered through BlueCard, a Blue Cross® and Blue Shield® Association program. Please refer to the BlueCard® Program Section 7.21 for specific details on how services are paid. It tells you what you must pay under the exclusions and limitations of this Rider.

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

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

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

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܡܥܘܕܪܝܬܘܢ ، ܣܢܝܩܐ ܗ̇ܘ ܥܘܕܪܢܐ، ܐܝܬܠܘܟܘܢ ܙܕܩܘܬܐ ܕܡܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܐ ܕܝܘܟܘܢ ܕܠܐ ܛܝܡܐ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘ ܥܠ ܡܢܝܢܐ ܕܬܫܡܫܬܐ ܕܥܡܝܠܐ ܥܠ ܚܨܐ ܕܟܪܛܝܣܟܘܢ ܐܘ 877-469-2583 TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,
fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services,
200 Independence Ave, S.W., Washington, D.C. 20201,
phone: 800-368-1019, TTD: 800-537-7697,
email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.