Welcome

TO BLUE CARE NETWORK

Member Handbook

with your *Certificate of Coverage* and riders

Confidence comes with every card.®

bcbsm.com

Quick Reference

IMPORTANT OR FREQUENTLY USED PHONE NUMBERS

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

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

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

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

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

WebMD Health Services is an independent company supporting Blue Care Network by providing health and well-being services.

Dear Sample Wayne State Univ Low Opt:

Welcome to Blue Care Network!

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

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

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

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

Sincerely,

KATHRYN G. LEVINE, PRESIDENT AND CEO

NOTE

We've highlighted key terms, important phone numbers and helpful information throughout the book.

CALL

Customer Service

1-800-662-6667
711 (TTY users)
8 a.m. to 5:30 p.m. Monday through Friday

MAIL

Mail inquiries to:

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

In your letter, include your name, address, phone number and enrollee ID as shown on your BCN ID card.

WALK-IN

Walk-in centers

Speak to a representative in person. Hours are 9 a.m. to 5 p.m. Monday through Friday. Call Customer Service or search *walk-in centers* at **bcbsm.com** to find locations near you.

Contents

Thank you for being part of Blue Care Network.

We want to help you understand your medical health care costs. And this card is a convenient way to help you keep track. Detach it and keep it with your health plan ID card so you'll know what you may have to pay when you receive certain covered medical services*.

Consider the card another helpful tool to use along with your *Member Handbook*, where you'll find these sections:

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

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

Your costs Printed on: 02/03/2020
PCP visit: $20 copay
Specialist visit: $20 copay
Urgent care: $20 copay
ER: $100 copay
Deductible: None
Coinsurance max: None
Out-of-pocket max: $6,350 per member/$12,700 per family

Your costs Printed on: 02/03/2020
PCP visit: $20 copay
Specialist visit: $20 copay
Urgent care: $20 copay
ER: $100 copay
Deductible: None
Coinsurance max: None
Out-of-pocket max: $6,350 per member/$12,700 per family

**Other costs may apply for primary care physician and specialist visits if additional services are performed in the office.*

Blue Care Network of Michigan

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

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

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

_____ _____

(Name) (Phone)

Blue Care Network of Michigan

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

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

_____ _____

(Name) (Phone)

1.Getting Started

1 REGISTER FOR AN ONLINE MEMBER ACCOUNT

With a secure member account at **bcbsm.com**, you can manage your health care plan, including selecting a primary care physician. You can also see a summary of your benefits, recent claims and out-of-pocket costs, such as your copayments.

Get started by going to **bcbsm.com/register** or downloading the Blue Cross® app. Search "**BCBSM**" in the Apple App Store® or Google Play™.

2 CHOOSE A PRIMARY CARE PHYSICIAN

Your primary care physician is the person you think of as "your doctor." **We must have one on file for you and everyone on your contract, and each doctor has to be a primary care physician in your plan's network**. For care to be covered or cost you the least, your primary care physician must coordinate your health care from preventive services to referrals for specialists. If we don't have a primary care physician on file for you, we'll assign one to you. We'll mail you a letter with the details if we do.

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

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

NOTE

Always carry your BCN Member ID card.

Using the Blue Cross app, you'll always have your BCN member ID card with you. Just log in to your account and tap the card icon.

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

***Google Play and the Google Play logo are trademarks of Google Inc.*

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

4 **KNOW THE REFERRAL PROCESS**
Your primary care physician will provide your care or refer you to a specialist. If your care isn't coordinated by your doctor, it may not be covered by your plan. For more information, see the referrals page in this section.

NOTE

Covered services
These are health care services, prescription drugs and equipment or supplies that are medically necessary, meet requirements and are paid in full or in part by your plan.

How you may share costs with us

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

Beginning of your plan year

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

Once you've met your deductible (if applicable)

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

Once you've reached the out-of-pocket maximum(s)

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

At the end of the plan year

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

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

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

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

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

Referrals / COORDINATING CARE WITH YOUR DOCTOR

Your primary care physician provides your care or coordinates it through BCN's referral process. When your doctor decides that you need specialty care, he or she will provide a referral, which allows you to receive treatment or services from another health care provider. Some PCPs are affiliated with certain groups of doctors and hospitals and will generally refer you to them for any care you need. This helps them better coordinate your care.

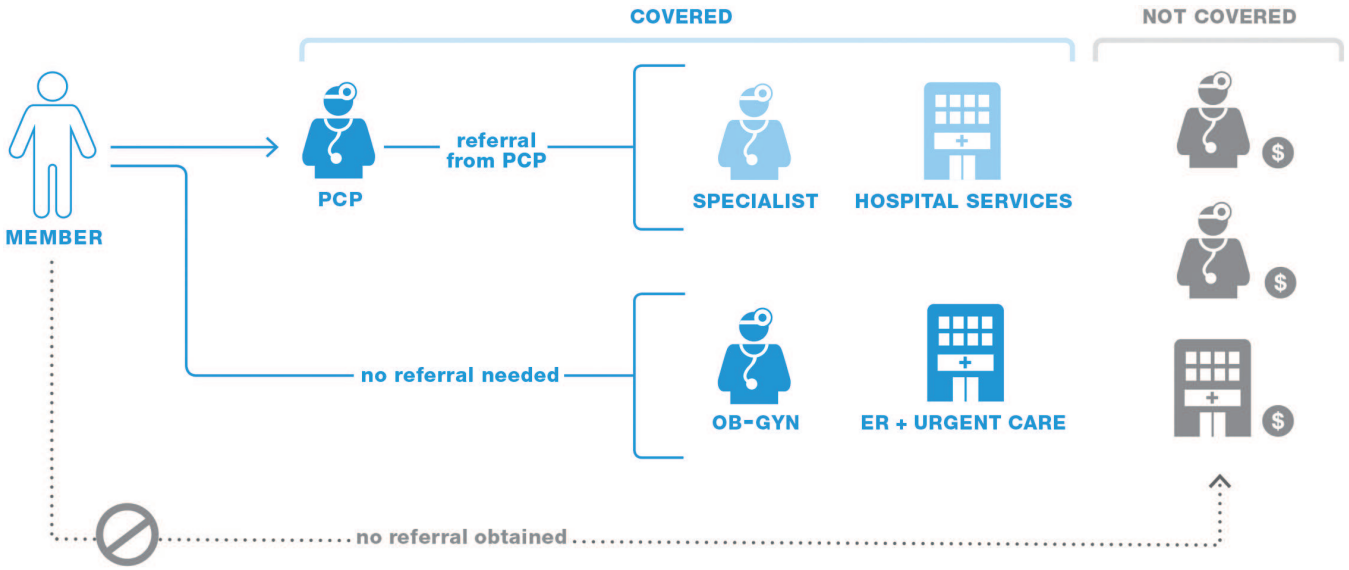
- It's important to confirm that your PCP refers you to an in-network specialist to ensure you're covered for treatment. You may need special approval from BCN for certain services and for services from specialists who aren't part of your plan's network.
- Your referral for treatment can range from 90 days to 365 days.
- Changing your PCP while a specialist is treating you may change your treatment referral. Check with your new PCP.
- Without a referral, you're responsible for the cost of services.
- View your referrals and authorizations by logging in to your member account at **bcbsm.com,** or through our app. Select *My coverage* and then *Referrals and authorizations*. When a new or updated referral and authorization is posted to your account, you'll get an email notification.* We'll also mail you an approval or denial letter.

NOTE **You don't need a referral for emergency care.**

NOTE **You don't need a referral for behavioral health, but you must be seen by a network provider.** For more information, see "How to use your benefits."

NOTE **No referral needed when female members see a network gynecologist or obstetrician** for annual well-woman visits and obstetrical care (Woman's Choice program).

To find a gynecologist or an obstetrician, log in to your member account at **bcbsm.com**, and click *Doctors & Hospitals* in the navigation menu.



*Not all approval and denial letters are handled by Blue Care Network. Only letters we send to you are available through your member account.

BCN authorization

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

In-network vs. out-of-network care

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

IN NETWORK

In-network providers are part of your plan's network. Be sure that your PCP refers you to in-network providers so your care is covered.

OUT OF NETWORK

Out-of-network providers aren't part of your plan's network. Except in an emergency or when your service is preauthorized by BCN, you're responsible for the entire cost of the service received from these providers.

If your doctor isn't in your plan's network

To continue care with a doctor who's not in your plan's network, one of these situations **must** apply to you:

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

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

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

Update your records / LIFE EVENTS

Report address changes or life events to your group benefits representative within 31 days of when they happen:

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

Coordination of benefits

WHEN YOU HAVE MORE THAN ONE PLAN

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

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

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

Coordination of benefits

COST

When you have more than one health care or prescription drug policy, coordination of benefits determines which plan pays your claims first (this is called your primary plan). If your primary plan doesn't pay the claim or pays only part, it's passed on to your secondary plan for payment review.

Advance directives / MAKE YOUR WISHES KNOWN

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

Types of advance directives are:

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

Download the forms from **bcbsm.com.** Type "advance directive" into the search box.

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

Advance directives

NOTE

Instructions regarding what future health care actions or medical treatments you want done, and when. These instructions are used when you're unable to communicate them yourself.

NOTE

Michigan doesn't recognize living wills.

2. How to Use Your Benefits

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

When you need medical care

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

GUIDE TO GETTING MEDICAL CARE

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

Your benefits when you travel

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

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

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

PHARMACY COVERAGE

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

EMERGENCY CARE

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

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

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

MEDICAL SUPPLIES AND EQUIPMENT

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

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

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

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

NOTE

Durable medical equipment

Special supplies or equipment, such as wheelchairs and oxygen tanks, that your PCP prescribes

NOTE

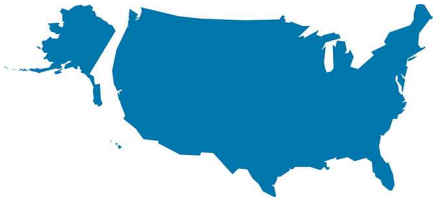
Diabetic supplies

Diabetic materials that your PCP prescribes, including insulin pumps and blood glucose meters

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

***J&B Medical Supply Company is an independent company that provides diabetic materials for Blue Care Network of Michigan.*

GUIDE TO YOUR BENEFITS WHEN YOU TRAVEL

Where you are	Type of care	What you need to do
In Michigan 	**Emergency care** *The symptoms are severe enough that someone with average health knowledge believes that immediate medical attention is needed.*	Call 911 or go to the nearest hospital emergency room.
	Urgent care *The condition requires a medical evaluation within 48 hours.*	Go to the nearest urgent care center. To locate an urgent care center, call Customer Service or visit **bcbsm.com/find-a-doctor.**
	Nonurgent care	Call your primary care physician to coordinate services that don't require immediate attention.
In the United States but outside Michigan 	**Emergency care**	Call **911** or go to the nearest hospital emergency room.
	Urgent care	Go to the nearest urgent care center. To locate an urgent care center, call BlueCard* at **1-800-810-BLUE (2583)**.
	Routine care *To treat or monitor a chronic condition or illness*	Call Customer Service for details about your health benefits and required authorizations. Call BlueCard at **1-800-810-BLUE (2583)** to find a physician at your destination.
	Other services *Such as elective surgeries, hospitalizations, mental health or substance use disorder services*	Call Customer Service for details about your health benefits and to determine which services require authorization.
Outside the United States 	**Emergency care**	Go to the nearest hospital emergency room. *You may be required to pay for services and then seek reimbursement. Be sure to get an itemized bill and medical records to speed reimbursement.*

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

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

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

Blue Cross Online Visits℠

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

- A doctor for minor illnesses such as a cold, flu or sore throat when your primary care physician isn't available. Medical visits are available 24/7.
- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief. Behavioral health visits are available by appointment only.

HOW TO GET STARTED

Here's how to use online visits:

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

No service key is required.

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

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

NOTE Learn more about your non-emergency choices for care at **bcbsm.com/findcare.**

**Online medical care doesn't replace primary care physician relationships. Remember to coordinate all care through your PCP.*

Lab services

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

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

Pain management

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

Medical supplies and equipment

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

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

When you purchase medical equipment, you might have to share the cost with BCN through copays or coinsurance.

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

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

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

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

NOTE

Durable medical equipment and diabetic supplies must be prescribed by your PCP and must be supplied by Northwood or J&B. If you get these items through someone else, you'll be responsible for the cost.

**JVHL is an independent company that provides lab services for Blue Care Network of Michigan.*

Behavioral health coverage

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

Behavioral health care managers are available 24 hours a day, seven days a week for emergencies at **1-800-482-5982 (TTY users call 711).** You don't need a referral from your PCP. However, you must be seen by a doctor in your plan's network.

NOTE

Call **1-800-482-5982** (TTY 711) Monday through Friday from 8 a.m. to 5 p.m. with questions about your behavioral health coverage, help finding a provider, or to request the guidelines we use to make medical necessity decisions.

GUIDE TO GETTING BEHAVIORAL HEALTH SERVICES

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

Some services aren't covered

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

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

Special care for women

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

BREAST RECONSTRUCTION FOLLOWING A MASTECTOMY

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

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

HOSPITAL STAYS FOR CHILDBIRTH

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

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

3. Your Drug Benefit

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

Your prescription drug coverage

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

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

NOTE

Download our Mobile App

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

Your drug list

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

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

How tiers work

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

TIER 1 • Lowest copay

You pay the lowest copay for generic and certain brand-name medications. *Some members have a benefit that places generic drugs into these two tiers:*

TIER 1A • Lower generic copay

These drugs are used to treat chronic diseases like high blood pressure, high cholesterol, diabetes, heart disease and depression.

TIER 1B • Higher generic copay

Includes generic medications that don't fall into Tier 1A.

TIER 2 • Preferred brand copay

This tier includes brand-name drugs that don't have a generic equivalent. These drugs are generally more expensive than generic medications.

TIER 3 • Nonpreferred brand copay

This tier has a higher copay than Tier-1 or Tier-2 drugs, and includes brand-name drugs for which there's either a generic alternative or a more cost-effective brand. Please note that these drugs may not be covered.

Specialty drugs

TIER 4 • Preferred specialty

These specialty drugs are generally more cost-effective than specialty drugs in Tier 5 and have the lowest specialty drug copay.

TIER 5 • Nonpreferred specialty

These specialty drugs have the highest copay because there may be a more cost-effective generic or brand option available.

Specialty drugs treat complex conditions, such as cancer, chronic kidney failure and multiple sclerosis, and may require special handling and monitoring.

For these drugs, you'll pay the applicable cost share for each prescription. Starting January 1, 2020, all specialty drugs must be obtained from AllianceRx Walgreens Prime.*

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

Keeping down costs with generic drugs

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

DISPENSE AS WRITTEN

Sometimes, physicians prescribe brand-name drugs to be "dispensed as written." In addition to your copay, you'll have to pay the difference in cost between the brand-name drug and the price of its generic equivalent.

Some drugs don't have a copay

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

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

Some drugs need approval

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

If the drug is not approved, you may have to pay the full cost of the drug.

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

COST

Coordination of drug benefits

If you're covered by more than one prescription drug plan, present both cards to your pharmacy when you get a prescription filled. The plan that's primary pays first.

Depending on your prescription drug coverage, the pharmacy may be able to bill BCN directly to cover some or all of your costs, or you may be eligible for reimbursement.

The reimbursement request form can be downloaded from **bcbsm.com/billform**. For a paper copy, call Customer Service.

Filling a prescription

AT A RETAIL PHARMACY

More than 2,400 retail pharmacies in Michigan and 70,000 retail pharmacies outside of Michigan accept your BCN member ID card. You may fill all prescriptions (except for specialty drugs) at any of these pharmacies.

- You may also save on your copays by getting up to a 90-day supply of your prescription at a retail pharmacy.
- An initial 30-day trial period is required before a 90-day supply of a brand-name prescription is covered.

Quantity limits

Because BCN strives to provide you with the most cost-effective therapy, a drug may have a limit on the amount that can be dispensed.

MAIL ORDER (HOME DELIVERY)

You can receive your prescriptions from our mail-order vendor, Express Scripts.* Mail-order prescriptions for most nonspecialty medications can be written for up to a 90-day supply. What you pay depends on your drug rider.

Contact Express Scripts at **1-800-229-0832**.

SPECIALTY DRUGS

Starting January 1, 2020, specialty drugs must be ordered from AllianceRx Walgreens Prime.

Call AllianceRx Walgreens Prime at **866-515-1355**.

Or visit **alliancerxwp.com**.

Blue Care Network of Michigan doesn't control this website and isn't responsible for its general content.

NOTE

Prescriptions for specialty drugs are limited to a 30-day supply for all fills. Some specialty drugs are limited to a 15-day supply.

LIMITED DISTRIBUTION SPECIALTY DRUGS

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

YOUR DOCTOR MUST MAIL OR FAX A NEW PRESCRIPTION

Express Scripts and AllianceRx Walgreens Prime **don't** accept telephone orders for new prescriptions. Your doctor can mail or fax the first prescription. Or, you can mail a request form with your original prescription. Download the form at **bcbsm.com**, or call Customer Service.

If you have questions about where to get your prescription, please call Customer Service at the number on the back of your ID card.

Or visit **bcbsm.com/pharmacy**.

**Express Scripts® is an independent company that provides pharmacy benefit management services for Blue Care Network of Michigan.*

Some drugs and medical supplies aren't covered

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

- Prescription drugs for which there's an over-the-counter equivalent in both strength and dosage form (unless the drug is considered preventive by the U.S. Preventive Services Task Force)
- Drugs used for experimental or investigational purposes
- Cosmetic drugs
- Drugs included as a medical benefit (such as injectable drugs and vaccines that are usually given in a doctor's office)

  Note: BCN members can get select vaccines at network retail pharmacies (quantity and age restrictions may apply).
- Replacement prescriptions resulting from loss, theft or mishandling
- Compounded drugs — with some exceptions
- Drugs not approved by the FDA
- Proton pump inhibitors, non-sedating antihistamines and nasal steroids (These medications have over-the-counter alternatives that are available without a prescription.)

Check your drug rider for additional items that may not be covered.

If you refill a prescription too soon or if your doctor prescribes an amount that's more than the limit that BCN allows, the drug may not be covered.

4. Your Benefits at a Glance

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

Understanding your benefits

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

When reading the table, keep in mind that only your primary care physician, or PCP, can refer you to specialty care. If your PCP doesn't refer you, you're responsible for the cost of services. BCN also needs to authorize certain services.

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

For information about all your benefits and how your deductibles, coinsurance and copays work, refer to your legal documents, your *Certificate of Coverage* and riders.

- **To see your certificate and riders,** log in to your account at **bcbsm.com.** Click *My Coverage* in the navigation menu, select *Medical* from the drop-down menu, click *Plan Documents* and scroll down to *Certificates and Riders.*
- To view your SBC online, log in to your account at **bcbsm.com.**
- To request a paper copy of these documents, call Customer Service at **1-800-662-6667.**

COMMONLY USED BENEFITS

Annual Deductible| Coinsurance and Out-of-Pocket Maximum	
Deductible	This health plan has no deductible.
Annual coinsurance maximum	This plan has no coinsurance maximum.
Out-of-Pocket Maximum - deductibles copays and coinsurance amounts for covered services apply to the out-of-pocket maximum	$6,350 per individual, $12,700 per family out-of-pocket maximum per calendar year
Physician Office Services	
Primary care physician visits	$20 copay per PCP office visit. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. $20 copay per visit with a designated online BCN participating provider.
Specialist visits	$20 copay per specialist office visit when referred. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. Spinal manipulations are unlimited when provided by a chiropractor or osteopathic physician and referred.
Maternity	$20 copay for postnatal maternity visits. Prenatal visits are covered in full. See Hospital Care below for facility charges.
Allergy office visit	$20 copay for allergy office visits
Immunizations	Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.
Emergency Services	
Emergency room	$100 copay for emergency room treatment. ER copay waived if admitted as an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.
Urgent care center	$20 copay per urgent care visit
Emergent ambulance services	Emergency ambulance transport is covered in full when other transportation would endanger a member's life.
Non-emergent ambulance services	Non-emergent ambulance transport is covered in full. Requires prior authorization by BCN.
Diagnostic and Therapeutic Services	
Lab and pathology services	Lab and pathology services are covered in full.
X-ray	X-ray and radiology services are covered in full. Prenatal ultrasound and other preventive services are covered in full.
Outpatient facility visits/diagnostic services	Outpatient diagnostic or therapeutic services covered in full. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full.
Radiation therapy	Radiation therapy in an inpatient or outpatient facility setting is covered in full.

COMMONLY USED BENEFITS continued

Diagnostic and Therapeutic Services	
Chemotherapy	Chemotherapy in an inpatient or outpatient facility setting is covered in full. Chemotherapy drugs are covered in full.
Dialysis	Dialysis treatment in an inpatient or outpatient facility setting is covered in full.
Hospital Care	
Inpatient hospital admission	Inpatient hospital admission covered in full; unlimited days. See certificate for specific surgical coinsurance.
Newborn care	Newborn care in an inpatient setting is covered in full.
Alternatives to Hospital Care	
Skilled nursing facility	Services in a skilled nursing facility are covered in full.
Skilled nursing facility days	Limited to 730 days of skilled nursing care in a skilled nursing facility. Requires prior authorization by BCN.
Hospice	Inpatient and outpatient hospice covered in full. Inpatient care requires prior authorization.
Home care visits	$20 copay per day for home care visits
Surgical Services	
Outpatient surgery facility	Outpatient surgery covered in full. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.
Second surgical opinion	$20 copay for second surgical opinion when referred
Surgical assistant	Services performed by a surgical assistant are covered in full.
Anesthesia	Anesthesia is covered in full.
Sterilization procedures	Adult sterilization is covered in full.
Elective abortion procedures	First trimester elective abortion is covered in full. Limited to one procedure per 24 month period.
Weight reduction procedures (criteria required)	Weight reduction procedures are covered in full. Requires prior authorization by BCN. Limited to one procedure per lifetime.
Orthognathic surgery	Orthognathic surgery is covered in full.
Behavioral Health Services (Mental Health Care and Substance Use Disorder) Call 1-800-482-5982 when you need care.	
Inpatient mental health	Inpatient mental health/partial hospitalization per hospital admission covered in full. Requires prior authorization by BCN.
Inpatient mental health days	Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.
Inpatient mental health time period	Coordinated by BCN Behavioral Health management

COMMONLY USED BENEFITS continued

Behavioral Health Services (Mental Health Care and Substance Use Disorder) Call 1-800-482-5982 when you need care.	
Outpatient mental health	$20 copay per visit for outpatient/intensive mental health. $20 copay per online mental health visit with a designated online BCN participating provider. Prior authorization not required for routine psychotherapy visits.
Outpatient mental health visit limit	Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.
Outpatient mental health additional visits	Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.
Inpatient substance use disorder	Inpatient substance use disorder/partial hospitalization covered in full. Requires prior authorization by BCN Behavioral Health management.
Inpatient substance use disorder time period	Coordinated by BCN Behavioral Health management
Outpatient substance use disorder	$20 copay per visit for outpatient/intensive outpatient substance use disorder. Prior authorization not required for routine psychotherapy visits.
Outpatient substance use disorder visit limit	Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.
Detoxification - substance use disorder	Detox services provided in an inpatient setting are covered in full. $20 copay per visit for outpatient detox services. Requires prior authorization by BCN.
Durable Medical Equipment Diabetic Supplies and Prosthetics and Orthotics For durable medical equipment and prosthetics and orthotics call Northwood at 1-800-667-8496. For diabetic supplies call J&B Medical Supply Company at 1-888-896-6233.	
Durable medical equipment	Durable medical equipment is covered in full. Breast pump to support breast feeding is covered in full. Must be preauthorized and obtained from a BCN supplier.
Diabetic supplies	Diabetic supplies and equipment covered in full. Must be preauthorized and obtained from a BCN supplier.
Prosthetics	Prosthetic appliances are covered in full. Must be preauthorized and obtained from a BCN supplier.
Orthotics	Orthotics are covered in full. Must be preauthorized and obtained from a BCN supplier.
Prescription Drugs	
Prescription drug coverage	Tier 1 - $5 copay, Tier 2 - $20 copay, Tier 3 - $45 copay. Includes contraceptive drugs. Drugs for the treatment of sexual dysfunction 50% coinsurance. Preventive medications and Tier 1 contraceptives are covered in full. 30-day supply. Mail order covered at the applicable tiered copay up to a 90-day supply.

COMMONLY USED BENEFITS continued

Other Services	
Allergy evaluation/serum/testing	Allergy related services are covered in full.
Allergy injections	Allergy injections are covered in full.
Infertility care (criteria required)	Infertility services are covered in full.. Requires prior authorization by BCN. In-vitro fertilization is not covered.
Outpatient physical| occupational and speech therapy/outpatient rehabilitation	$20 copay per visit for outpatient physical therapy and rehabilitation
Outpatient physical| occupational and speech therapy/outpatient rehabilitation limits	Limited to 60 visits per medical episode per plan year.
Autism spectrum disorder	$20 copay per visit for applied behavioral analysis. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.
Temporomandibular joint (TMJ)	TMJ services are covered in full. Requires prior authorization by BCN.
Hearing aid and evaluation	Hearing aid evaluation, testing and one hearing aid is available once every 36 months.

5. Information For You

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

BCN: Part of the Blue Cross family

Blue Care Network of Michigan is a health maintenance organization and an independent, nonprofit affiliate of Blue Cross Blue Shield of Michigan, one of many individual Blue Cross and Blue Shield plans throughout the United States. BCN is governed by an 18-member board of directors that includes physicians, members and other private citizens, as well as representatives of large business, small business, labor, hospitals and other health care providers.

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

- The Blue Cross and Blue Shield Association licenses Blue Care Network to offer certain products and services under the Blue Cross and Blue Shield names.
- Blue Care Network is an independent organization governed by its own board of directors and solely responsible for its own debts and other obligations.
- Neither the association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of Blue Care Network's obligations.
- Blue Care Network files an annual report with the Michigan Department of Insurance and Financial Services.

Your rights and responsibilities

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

ALL MEMBERS HAVE THE RIGHT TO…

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

ALL MEMBERS HAVE THE RESPONSIBILITY TO...

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

Grievance process

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

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

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

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

STEP ONE

You, or someone authorized by you in writing, must submit a standard grievance in writing.

By mail: Appeals and Grievance Unit, Blue Care Network, P.O. Box 284, Southfield, MI 48086-5043

Or by fax: **1-866-522-7345**

We'll review your concern and reply within 15-calendar days for preservice requests and 30-calendar days for postservice requests. The individuals who review the first level grievance are not the same ones involved in the initial decision. If we deny your grievance, we'll write to you and explain the reasons for the 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 AND DECISION MADE BY BCN GRIEVANCE PANEL

If your grievance is denied, you may request review by BCN's Member Grievance Panel. You must file the request within 180-calendar days of receiving the adverse Step One decision. For preservice requests, you'll be notified of the Step Two grievance decision within 15-calendar days. For postservice 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 preservice or 60 days for postservice requests) and explain the reasons for the denial. Please note that the decision may take an additional 10 business days if BCN needs to request medical information. We'll also tell you what you can do next. At your request and at no charge to you, we'll provide all documents used in making the decision

EXTERNAL REVIEW BY THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

If you don't agree with our decision at Step Two or if we are late in responding (add 10 business days if we ask for additiional medical information), you'll be considered to have exhausted the internal grievance process. At this point, you may appeal to the Department of Insurance and Financial Services. You must send your grievance no later than 127-calendar days following receipt of our decision. Send your external review request to: Appeals Section — Office of General Counsel, Department of Insurance and Financial Services.

By mail: P.O. Box 30220, Lansing, MI 48909-7720
or by personal delivery: 530 W. Allegan Street, 7th Floor, Lansing, MI 48933-1070

By phone: **1-877-999-6442**, or by fax: **517-284-8838**

Online*: **difs.state.mi.us/Complaints/ExternalReview.aspx**

OTHER STEPS FOR APPEALING CLAIM DECISIONS

If you're a member of an ERISA- (Employee Retirement Security Act) qualified group, you have the right to bring a civil action against Blue Care Network after completing BCN's internal grievance procedures.

Non-ERISA group members and nongroup members must exhaust all grievance steps (including review by the Department of Insurance and Financial Services) before filing civil action. If you don't know if your group is an ERISA-qualified group, check with your employer.

**Blue Care Network of Michigan doesn't control this website or endorse its general content.*

EXPEDITED REVIEW FOR APPEALS

Under certain circumstances — if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review — you can request an expedited review. We'll decide within 72 hours of receiving both your grievance and your physician's confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days.

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

You, your doctor or someone acting on your behalf can initiate an expedited review by calling Customer Service at **1-800-662-6667** or faxing us at **1-866-522-7345.**

Quality assurance

MEDICAL REVIEW STANDARDS

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

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

OUR PHYSICIANS HAVE THE CREDENTIALS

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

Verify the license status of our health care providers at **michigan.gov/healthlicense***.

Or call the Michigan Department of Consumer and Industry Services at **517-241-7849.**

WE MONITOR THE CARE YOU GET

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

**Blue Care Network of Michigan doesn't control this website or endorse its general content.*

We would like you to know:

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

How we determine new health services

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

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

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

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

Quality management

Our quality improvement programs provide doctors with information to help improve care.

Call our Quality Management department for more information about our programs and guidelines.

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

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

Accreditation

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

Privacy practices

NOTICE OF PRIVACY PRACTICES

FOR MEMBERS OF OUR NONGROUP AND UNDERWRITTEN GROUP PLANS INCLUDING MEDICARE ADVANTAGE AND PRESCRIPTION BLUE OPTIONS A AND B.

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

AFFILIATED ENTITIES COVERED BY THIS NOTICE

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

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

OUR COMMITMENT REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

OUR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your PHI for the following purposes without your authorization:

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

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

For payment: We may use and disclose your PHI for our payment-related activities and those of health care providers and other health plans, including:

- Obtaining premium payments and determining eligibility for benefits
- Paying claims for health care services that are covered by your health plan
- Responding to inquiries, appeals and grievances
- Coordinating benefits with other insurance you may have

For health care operations: We may use and disclose your PHI for our health care operations, including for example:

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

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

- **To others involved in your care:** We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or relative, unless you object.
- **When required by law:** We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of the Department of Health and Human Services and state regulatory authorities.

- **For matters in the public interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:
  - Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight
  - Reporting adult abuse, neglect or domestic violence
  - Reporting to organ procurement and tissue donation organizations
  - Averting a serious threat to the health or safety of others
- **For research:** We may use and disclose your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.
- **To communicate with you about health-related products and services:** We may use your PHI to communicate with you about health-related products and services that we provide or are included in your benefits plan. We may use your PHI to communicate with you about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees and add value to your benefits plan.
- **To our business associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.
- **To group health plans and plan sponsors:** We participate in an organized health care arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information (although we are prohibited from using or disclosing any genetic information for underwriting purposes). Certain plans and their sponsors may receive additional PHI from BCBSM and BCN. Whenever we disclose PHI to plans or their sponsors, they must follow applicable laws governing use and disclosure of your PHI including amending the plan documents for your group health plan to establish the limited uses and disclosures it may make of your PHI.

  You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Some uses and disclosures of your PHI require a signed authorization:
- **For marketing communications:** Uses and disclosures of your PHI for marketing communications will not be made without a signed authorization except where permitted by law.
- **Sale of PHI:** We will not sell your PHI without a signed authorization except where permitted by law.

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

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

DISCLOSURES YOU MAY REQUEST

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

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

Forms are also available at **bcbsm.com**.

INDIVIDUAL RIGHTS

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

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

Forms are also available at **bcbsm.com**.

- **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable cost-based fee for copying and postage. You may request that these materials be provided to you in written form or, in certain circumstances, electronic form. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.
- **Disclosure accounting:** You have the right to an accounting of disclosures, we, or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment and health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

  You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.
- **Restriction requests:** You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment or health care operations. We are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.

- **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under "Access." If we deny your request, we will provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.
- **Confidential communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits Statement to a post office box instead of to the subscriber's address.

  To request confidential communications, call Customer Service at **1-800-662-6667** or **313-225-9000.**
- **Breach notification:** In the event of a breach of your unsecured PHI, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

QUESTIONS AND COMPLAINTS

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

Write us at: Blue Cross Blue Shield of Michigan, *Attn:* Privacy and Security Official, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226-2998.

Or call us at **313-225-9000.**

For your convenience, you may also obtain an electronic (downloadable) copy of this notice online at **bcbsm.com.**

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

Call us at **1-800-552-8278.**

You may also complete our *Privacy Complaint Form* online at **bcbsm.com.**

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

6. Your benefit documents

The documents that follow provide details about your benefits, including what you may owe when you get services. These documents are the contract between you, your group and Blue Care Network.

Blue Care Network
Certificate of Coverage
BCN1 for 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 is a product of BCN, an independent corporation operating under a license from the Blue Cross® and Blue Shield® Association. This Association is made up of independent Blue Cross® Blue Shield® plans. It permits BCN to use the Blue Cross® Blue Shield® Service Marks in Michigan.

When you enroll, you understand the following:

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

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

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

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.

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

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, which may be enrolled with BCN as either a Subscriber or Family Dependent.

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

Acute Illness or Injury is one that is characterized by sudden onset (e.g., following an injury) or presents as an exacerbation of disease and is expected to last a short period 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 payment level BCN will pay for the Covered Service. The Approved Amount is reduced by any Cost Sharing, which may be required of you, before we make our payment.

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

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

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

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, 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 Approved Amount that you owe after you pay any Deductible. This amount is determined based on the Approved Amount at the time the claims are processed. Your Coinsurance is not altered

by an audit, adjustment or recovery. Your Coinsurance is added or amended when a Rider is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

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

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

Copayment (Copay) is a fixed dollar amount you may 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.

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. Your Deductible is not altered by an audit, adjustment, or recovery. Your Deductible amount is added or amended when a Rider is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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

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

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

Emergency Medical Condition is an illness, injury or symptom that requires immediate medical attention to avoid permanent damage, severe harm or loss of life. (See Section 8 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 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 of this Certificate. It describes the rules of your health care Coverage.

Grievance is a written dispute about coverage determination 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.

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

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.

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

Medical Episode is an acute incidence of illness or symptoms that is distinct from the Member's usual state of health and has a defined beginning and end. It may be related to an illness but is

distinctly separate. (Example: A Member may have Chronic arthritis of the knee but may have an acute flare-up that makes the Member unable to walk. The acute flare-up would have a distinct beginning, would run a distinct length of time and finally revert back to the Chronic state.)

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

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

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

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

Non-Participating 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 Online Visit is for the purpose of diagnosing and providing medical or other health treatment for low-complexity conditions within the provider's scope of practice.

Open Enrollment Period is 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. The Out-of-Pocket Maximum amount may be amended when a Rider is attached.

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

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

PCP Referral 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, Preauthorized Service or Prior Authorization is health care Coverage described in this Certificate and 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 disease. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

Primary Care Physician (PCP) is the Participating Provider you choose to provide or 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 Practitioners (CNP)
- Licensed Psychologist (LP)
- Limited License Psychologist (LLP)
- Licensed Professional Counselor (LPC)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Certified Nurse Midwife (CNM)
- Board Certified Behavior Analyst (BCBA)
- Clinical Nurse Specialist – Certified (CNS-C)
- Other providers as identified by BCN

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 in a nursing home, hospice Inpatient Facility, or Hospital so that your family member, friend or caregiver 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 may apply a Copayment, Deductible, Coinsurance and Out-of-Pocket Maximum to select Covered Services. When there is a conflict between the Certificate and a Rider, the Rider shall control over the Certificate.

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

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

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

Skilled Care means services that:

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

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

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

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

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

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Chapter 1 — GENERAL PROVISIONS

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

This section describes eligibility, enrollment and effective date of Coverage.

1.1 Eligibility

You must meet eligibility requirements set by 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.

A. Group Subscriber

You must do all of the following:

- Live in the BCN Service Area
- Be a member, an active employee, or eligible retiree of a Group
- 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, and 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 employer contributions or loss of eligibility.

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

Effective Date

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

B. Family Dependents and Dependents under a Qualified Medical Child Support Order

A Family Dependent may be:

- The legally married spouse of the Subscriber
- A 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. The Dependent Child's children may be covered in limited circumstances.

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

- A Dependent under a Qualified Medical Child Support Order

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

Exception: An unmarried Dependent Child and 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; and
- 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 by the end of the Calendar Year in which the child turns 26.

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

Dependent under a Qualified Medical Child Support Order

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 ID card.

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 a court or administrative 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 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 dis-enroll 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 after 31 days of the court or administrative order, Coverage is effective on the date BCN receives notice.

C. Principally Supported Child

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, and
- Be dependent on the Subscriber for principal financial support in accordance with Internal Revenue Service standards, and have met these standards for at least 6 full months prior to applying for Coverage.

You may apply for Coverage for a Principally Supported Child after you have been the principal support for 6 months.

To apply, you must furnish the following:

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

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 Group must remit premium to BCN prior to the effective date of coverage.

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, BCN 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 the Group and the Group agrees to notify BCN within 31 days of any change in eligibility status of you or any Members on the Contract. The Subscriber and Family Dependents are jointly and severally responsible for payment for any services or Benefits received from BCN after the Subscriber and Family Dependent(s) ceases to be eligible for Coverage pursuant to the terms of this Certificate regardless of whether or not notice was given. When you are no longer eligible for Coverage, you are responsible for payment for any services or benefits.

- BCN will only pay for Covered Services you receive when you are a BCN Member covered under this Certificate. If you are admitted to a Hospital or Skilled Nursing Facility either when you become a Member or when your BCN membership ends, BCN will only pay for Covered Services provided during the time you were a Member.

1.2 Enrollment

- Persons who are eligible to enroll during an Open Enrollment Period must enroll at that time or must wait until the next Open Enrollment Period;

- Persons who first become eligible to enroll at a time other than during the Open Enrollment Period must enroll within 31 days of becoming eligible. For example, new Employees will be allowed 31 days from the date of becoming eligible to enroll regardless of when the Group's Open Enrollment Period is;

- Eligible newborn children will be covered from birth if enrolled within 31 days of birth (See Section 1.1.); and

- To enroll, a completed enrollment application must be submitted to the Group and the application and appropriate premium amount must be received by BCN from the Group.

1.3 Effective Date of Coverage

Subscribers and other Family Dependents will be covered under this Certificate on the effective date of Coverage agreed upon between the Group and BCN after all of the requirements below have been met:

– The names of the Subscriber and enrolled Family Dependents have been received from the Group in writing by BCN.

– The appropriate premium has been received by BCN from the Group for all listed Subscribers and enrolled Family Dependents.

– BCN will only pay for Covered Services you receive when you are a BCN Member covered under this Certificate. If you are admitted to a Hospital or Skilled Nursing Facility either when you become a Member or when your BCN membership ends,

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; and
- 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 provides each Member with full health care services within the limits of this Certificate.
- BCN does not duplicate benefits provided or paid for by another party nor provide a Member with greater benefits than the actual expenses incurred.
- Benefits under this Plan will be reduced to the extent that they are available or that reimbursement is payable under any other group certificate, group insurance policy, or other group program covering the Member whether or not a claim is made for the benefits.
- Benefits will be coordinated, as outlined below, to provide 100% coverage in whole or in part under either plan but in no event will benefits be provided which would result in payments in excess of 100% of the total amounts to which providers or Members are entitled.
- As a health maintenance organization, BCN is not required to pay claims or coordinate benefits for services that are not provided or Preauthorized by BCN or BCN Participating Physician and which are not a Benefit under this Certificate. Under state law BCN is prohibited from making any direct monetary payment or reimbursement to Members related to services received except as specifically allowed by law.

2.2 Workers' Compensation and Auto Policy Claims

- Benefits under this Certificate exclude services and treatment for any work related injury to the extent that benefits are paid or payable under any workers' compensation program or other similar program. Where services are provided by

BCN, BCN is assigned the Member's rights to seek reimbursement from the other program or insurer.

- Benefits under this Certificate will not be reduced because of the existence of coverage under a Member's non-coordinated no-fault automobile policy; the health plan will assume primary liability to provide benefits available under this Certificate in accordance with this Certificate's terms and conditions.

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 or 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 31 days written advance notice. BCN will have the right to recover from you the value of services and benefits provided to you.

Section 3: Member Rights and Responsibilities

3.1 Confidentiality of Health Care Records

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

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

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

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

3.2 Inspection of Medical Records

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

3.3 Primary Care Physician (PCP)

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

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

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

Information on how to select a Primary Care Physician, and a list of Participating Primary Care Physicians, Participating pediatricians and Participating health care professionals (including certified and registered nurse midwives) who specialize in obstetrics or gynecology is available at bcbsm.com or by calling Customer Service at the number shown on the back of your BCN ID card.

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

3.4 Refusal to Accept Treatment

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

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

3.5 Grievance Procedure

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

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

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

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

Definitions:

Adverse Benefit Determination - means any of the following:

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

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

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

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

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

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

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

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

If you are dissatisfied with the determination, you may appeal to Step Two within 180-calendar days of receipt of BCN's adverse determination. You, or a person authorized in writing to act for you, must notify the Appeals and Grievance Unit in writing and at the address above of your decision to appeal. If you do not file a Step Two grievance within the 180-calendar day timeframe, your grievance is considered abandoned and no further action may be taken.

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

If you appeal from Step One, BCN's Step Two Member Grievance Panel will review and reconsider the determination made at Step One. You, or someone authorized by you in writing, may present the grievance to the Step Two Member Grievance Panel in person or by telephone conference. For Pre-Service and Post-Service grievances, notification of the Step Two grievance resolution will be sent to you within 15 calendar days for Pre-Service and 30 calendar days for Post-Service. If the grievance pertains to a clinical issue, the grievance will be forwarded to an independent Medical Consultant within the same or similar specialty for review. If BCN needs to request medical information, an additional 10 business days may be added to the resolution time. When an adverse determination is made, a written statement will be sent within 5-calendar days of the Panel meeting, but not longer than 15-calendar days for Pre-Service and 30 calendar days for Post-Service after receipt of the request for review. Written confirmation will contain the reasons for the adverse determination, the next step of the grievance process and the form used to request an external grievance review. BCN will provide, upon request and free of charge, all relevant documents and records relied upon in reaching an adverse determination.

External Review

If you do not agree with the decision at Step Two or our internal grievance process is waived, you may appeal to the Department of Insurance & Financial Services (DIFS) at https://difs.state.mi.us/Complaints/ExternalReview.aspx or at the addresses listed below:

Office of General Counsel – Health Care Appeals Section
Department of Insurance & Financial Services

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

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

Phone: 877-999-6442
Fax: 517-284-8838

When filing a request for an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If we fail to provide you with our final determination within 30-calendar days for Pre-Service grievances or 60-calendar days for Post-Service grievances (plus 10 business days if BCN requests additional medical information) from the date we receive your written grievance, you will be considered to have exhausted the internal grievance process and may request an external review. You must do so within 127 days of the date you received either our final determination or the date our final determination was due. Mail your request for a standard external review, including the required forms that we will provide to you, to the address listed above.

Expedited review

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

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

3.6 Additional Member Responsibilities

You have the responsibility to 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. You must call the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and develop mutually agreed upon treatment goals.
- Comply with the terms and conditions of the Coverage provided.

3.7 Member's Role in Policy-Making

At least one third of the Board of Directors of BCN will consist of BCN Members, elected by Subscribers. BCN provides nomination and election procedures to Subscribers every 3 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, as defined under PPACA, in connection with Coverage is cause for Rescission of your Contract upon 31 days written advance notice.

You have the right to appeal our decision to Rescind your Coverage by following the grievance procedure as described in Section 3 and in the Member Handbook. The grievance procedure is also available on our website at bcbsm.com.

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

4.2 Identification Card

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

To be entitled to Benefits, the person using the card must be the Member for whom all premiums have been paid. If the person is not entitled to receive services, the person must pay for the services received.

If you have not received your card or your card is lost or stolen, please contact Customer Service immediately. Information regarding how to obtain a new ID card is also available at bcbsm.com.

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; and
- BCN may copy records related to your care.

4.6 Member Reimbursement

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

Additional information on how to submit a claim and the Reimbursement Form is available at bcbsm.com and in the Member Handbook.

Send your itemized medical bills promptly to us.

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

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

Section 5: Termination of Coverage

5.1 Termination of Group Coverage

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

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

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

5.2 Termination for Nonpayment

Nonpayment of Premium

If a Group fails to pay the premium by the due date, the Group is in default. BCN allows a 30-day grace period; however, if the default continues, the Group and its Members may be terminated.

BCN will allow a 30-day grace period; however, if the Group or Member is terminated, any Covered Services incurred by a Member and paid by BCN after the date of last full payment will be charged to the Group or, as permitted by law, to the individual Member.

Nonpayment History

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

Nonpayment of Member's Cost Sharing

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

- You fail to pay applicable Copayments, Deductible, Coinsurance or other fees within 90 days of their due date; or
- 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 also 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
- You knowingly provide inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCN grievance procedure in Section 3 of this Certificate. You can also find a copy of the procedure in the Member Handbook and on our website at bcbsm.com. 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 **exce**pt:
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; or

   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; and
- Addressed to your last address provided to BCN.

7.2 Change of Address

You must notify your employer and BCN immediately if your address changes. 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

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

7.6 Assignment

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

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

7.7 Policies and Member Handbook

Reasonable policies, procedures, rules and interpretations may be adopted in order to administer this Certificate. Your Benefits include additional programs and services, as set forth in the Member Handbook.

7.8 Time Limit for Legal 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:

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

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

- Adjust premiums based on genetic information;
- Request/require genetic testing; or
- Collect genetic information from an individual at any time for underwriting purposes.

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

7.10 Reliance on Verbal Communication and Waiver by Agents

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

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

- Waive any conditions or restrictions of this Certificate; 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

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

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

7.12 Major Disasters

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

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

Such circumstances include, but are not limited to:

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

7.13 Obtaining Additional Information

The following information is available to you by writing to BCN Customer Service at P. O. Box 68767, Grand Rapids, MI 49516-8767.

- 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 also call our Customer Service Department at the number shown on the back of your BCN ID card. **NOTE:** Some of this information is in the Member Handbook and at bcbsm.com.

7.14 Right to Interpret Contract

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

7.15 Independent Contactors

BCN does not directly provide any health care services under this Certificate, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by health professionals in consultation with you. Participating Providers and any

other health professions providing health care services to under this Certificate do so as independent contractors.

7.16 Clerical Errors

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

7.17 Waiver

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

Chapter 2 – YOUR BENEFITS

Important Information

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

- The Services listed in this chapter are covered when Services are provided in accordance with Certificate requirements (including Referral from PCP or other Participating 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

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

- If you receive a Service that we do not cover, you will be required to pay for that Service.

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

- 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 only when referred by your PCP and Preauthorized or approved by BCN.

- If you purchase a deluxe item or equipment when not Medically Necessary, the Approved Amount for the basic item will apply 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 Benefit Maximums. When a Rider is attached to this Certificate, the Rider will take precedence.

  - You can find information about other Benefits as listed below, in the Member Handbook or at 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.

Section 8: Your Benefits

8.1 Cost Sharing

NOTE: Your employer may have chosen Cost Sharing to 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

Your plan may have fixed dollar Copayments defined in any Riders issued to you. Copayments count toward your Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum is met, you will not be responsible for Copayments for the remainder of the Calendar Year.

Coinsurance

Your plan may have a Coinsurance detailed in a Rider attached to this Certificate. Coinsurance applies toward your Out-of-Pocket Maximum. Once you reach Out-of-Pocket Maximum, you will not be responsible for Coinsurance for the remainder of the Calendar Year.

Cost Sharing – Deductible, Copayment and Coinsurance Calculation

If you have a Coinsurance or Copayment for a particular Service as well as a Deductible, you will first be responsible for the payment of the Deductible. The Coinsurance or Copayment 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 Copayment 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, Copayment and Coinsurance as defined in the Riders attached to this Certificate. The maximum amount is set annually by the federal government.

Once you reach the Out-of-Pocket Maximum, you will not pay Deductible, Copayments 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 defined by a Rider attached to this Certificate.

Benefit Maximum

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

8.2 Professional Physician Services (Other Than Behavioral Health Services)

We cover the following Services unless amended by a Rider.

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

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

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

  If an office visit Copayment Rider is attached, the PCP office visit Copay applies. If your Benefits have a Deductible and it applies to PCP office visits, then it will also

apply to Online Visits.

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

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

- 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.

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

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

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

C) 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.

D) Inpatient Professional Services provided while you are in an Inpatient Hospital or Skilled Nursing Facility or Inpatient Rehabilitation center and billed by a physician when Preauthorized by BCN

E) 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 Copayment 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
Visits for mechanical traction are applied toward your Benefit Maximum for physical. speech and language pathology, and occupational therapy services. The therapies (mechanical traction or physical, speech and language pathology, and occupational therapy) are limited to the Benefit defined under Physical and Rehabilitation Services section.

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

8.3 Continuity of Care for Professional 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 and under the circumstances listed below, the disaffiliated physician may continue treating you.

Physician Requirements
The Continuity of Care provisions apply only when your physician:

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

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

Medical Conditions and Coverage Time Limits

- Pregnancy Related: If you are in your second or third trimester of pregnancy at the time of the treating physician's disaffiliation, services provided by your physician may continue through post-partum care for Covered Services directly related to your pregnancy.
- Terminal Illness: If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the end of the provider's BCN contract, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.
- Life-threatening condition: If you have a life-threatening disease or condition for which death is likely if the course of treatment is interrupted. Coverage for Services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first.

- Other Medical Conditions: For Chronic (on-going) and Acute medical conditions (a disease or condition requiring complex on-going care such as chemotherapy, radiation therapy, surgical follow-up visits)when a course of treatment began prior to the treating physician's disaffiliation, Coverage for Services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first. The treating physician or health care provider must attest that your condition would worsen or interfere with anticipated outcomes if your care were discontinued. Your Participating Primary Care Physician must coordinate all other Services in order for them to be Covered Services.

Coverage

If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the "Physician Requirements" listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid, 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 and time periods described below:

Coverage Time Limits and Qualification Criteria

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

Coverage

Coverage will be provided for Covered Services for an ongoing course of treatment, subject to Coverage Time Limits and Qualification Criteria detailed above. In order for additional Covered Services to be paid, 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. The federal government may modify Preventive Services 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 screening
- Glaucoma screening
- EKG screening
- Vision and hearing screening (See Section 9 for exclusions and limitations)
- Type 2 diabetes mellitus screening
- Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)

B) Women's health and wellbeing

- Gynecological (well woman) examinations including routine pap smear and mammography screening
- Screening for sexually transmitted diseases; HIV counseling and screening
- Contraceptive counseling and methods; office administered 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 side effects
- Routine preventive prenatal office visits
- Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling
- Breast pump and associated supplies needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. Convenience items such as storage containers, bags, bottles and nipples are not covered. (See Durable Medical Equipment section for limitations and exclusions)

- 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 women 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; and
- Female sterilization Services

C) Newborn screenings and well child assessments and examinations
Vision and hearing examinations for children through the age of 17

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 only. If this Certificate is amended by Deductible, Copayment and 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; and
- 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 shown on the back of your BCN ID card.

8.5 Inpatient Hospital Services

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

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

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

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

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

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

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

- Newborn care

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

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

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

Newborn care includes:

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

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

8.6 Outpatient Services

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

You receive Outpatient Services in the following places:

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

Outpatient Services include but are not limited to the following:

- 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 Physical Therapy and Rehabilitation Services
- Injections (for allergy) - see Professional Physician Services (Other Than Behavioral Health Services) section
- Professional Services - see Professional Physician Services (Other Than Behavioral Health Services) section
- Durable Medical Equipment and supplies - see Durable Medical Equipment section
- Diabetic equipment and supplies - see Diabetic Supplies and Equipment section
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics section
- Other Medically Necessary Outpatient Services and supplies

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

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

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

Coverage

Emergency Services and Urgent Care Services are covered in full 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. Inpatient emergent admissions require Preauthorization by BCN.

Emergency Services include professional and related ancillary services and Emergency Services provided in an Urgent Care Center or hospital Emergency Room.

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

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.

Admission to Non-Participating Hospital after Emergency Services

If you are hospitalized in a Non-Participating Hospital, we may require that you be transferred to a Participating Hospital as soon as you have Stabilized. If you refuse to be transferred, all related non-Emergency Covered Services will not be covered from the date of Stabilization.

Out-of-Area and Non-Participating Coverage

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

For dates of Service beginning on or after 1/1/2020, when Services are rendered by a Non-Participating Provider, we pay the greater of:

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

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

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

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 Skilled Nursing Facility
- A Member's home
- A dialysis center

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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

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

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

Coverage 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

Air ambulance

Air Ambulance services must also meet these requirements:

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

- The Member is transported to the nearest facility capable of treating the Member's condition.

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

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

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 the following Services:

- Non-Elective abortion
- Genetic testing
- Adult sterilization
- Infertility
- Reproductive Care

A) Non-Elective Abortion

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

- To increase the probability of a live birth;
- To preserve the life or health of the child after live birth;
- To remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman;
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert their death; or
- Treatment upon a woman who 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 attached to 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; and
- Abortions otherwise prohibited by law.

B) Genetic Testing

We cover in full 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 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) Adult Sterilization

We cover in full adult sterilization procedures including Inpatient; Outpatient and office based services.

NOTE: Female sterilization is covered in full as defined in the federal Patient Protection and Affordable Care Act for Women's Preventive Services.

Exclusions include, but are not limited to

Reversal of surgical sterilization for males and females

D) Infertility

Except as provided in Section 9 services for diagnosis, counseling, and treatment of infertility are covered in full in accordance with generally accepted medical practice.

Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment will be undertaken only when determined by BCN to be in accordance with generally accepted medical practice.

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.

Exclusions include but are not limited to

- 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

E) Reproductive Care

History, physical examination, laboratory tests, advice, counseling, and medical supervision related to family planning, sex education, and prevention and prevention of venereal disease are covered in full in accordance with generally accepted medical practice.

8.10 Skilled Nursing Facility

We cover in full Skilled Nursing Care in a Skilled Nursing Facility up to a Benefit Maximum of 730 days when such care is Preauthorized by BCN as Medically Necessary for convalescence from surgery, disease, or injury.

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 in full. We also cover hospice care in the home. Hospice Care has to be Medically Necessary and Preauthorized by BCN.

Coverage

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

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

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 in full:

- 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.
- Hospice Care
- 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 in full 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 plan 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 psychotherapy services. (Mental Health Emergency Services are covered - see Emergency and Urgent Care section.)

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

Definitions

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

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

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program
- A structured environment that will allow the individual to reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long-term means of protecting others in the Member's usual living environment
- Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program"), however, the Benefit design will be the same as your medical Inpatient Benefit when Preauthorized by BCN

Partial Hospitalization Mental Health is a comprehensive Acute care program that consists of a minimum of 4 hours per day, at least 3 days a week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluations and Referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of Inpatient psychiatric hospitalization.

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

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

Coverage

Mental Health Care is covered in either an Inpatient or Outpatient setting. To obtain Services call Behavioral Health Management at the number shown on the back of your BCN ID card. They are available 24 hours a day/7 days a week. 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/Partial Hospitalization Coverage is the same as your medical Inpatient Benefit.

Outpatient Mental Health/Intensive Outpatient Mental Health

Your Outpatient mental health/Intensive Outpatient Mental Health Coverage is the same as your Primary Care Physician Benefit, 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 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 in a Treatment Plan.

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

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

Definitions

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

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

Partial Hospitalization is a comprehensive Acute Care program that consists of a minimum of 4 hours per day, 3 days 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 in a Treatment Plan.

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

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

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

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

Coverage

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

hours a day/7 days a week. You do not need a Referral from your Primary Care Physician to get care.

Cost Sharing

Detoxification/ Partial Hospitalization/Partial Domiciliary Substance Use Disorder

Your Detoxification/Inpatient/Partial Hospitalization/Partial Domiciliary Coverage is the same as your medical Inpatient Benefit.

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 Benefit, 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 Autism Spectrum Disorders

Definitions

Applied Behavioral Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct-observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved Autism Evaluation Center (AAEC) is an academic and hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

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

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

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

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

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

Benefits

Services for the diagnosis and treatment of ASD are covered when performed by a BCN approved Participating Provider. Covered diagnostic Services must be provided by a Participating licensed physician or a Participating licensed psychologist and include assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule. We cover Services for the treatment of ASD as follows.

- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's ASD
- Therapeutic care as recommended in the Treatment Plan includes:
  - Occupational therapy, speech and language therapy and physical therapy (when performed by a Participating occupational therapist, speech therapist and physical therapist);
  - ABA (when performed by a Participating BCBA and Participating psychologist);
  - Outpatient Mental Health therapy (when performed BCN Participating social worker, clinical psychologist and psychiatrist)
  - Social skills training
  - Genetic testing
  - Nutritional therapy
- Services and treatment must be Medically Necessary, Preauthorized and deemed safe and effective by BCN.
- Services that are deemed experimental or ineffective by BCN are covered only when mandated by law, and included in a Treatment Plan recommended by the BCN AAEC that evaluated and diagnosed the Member's condition and when approved by BCN.

Coverage

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

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

ABA for Line Therapy Services is covered the same as your Primary Care Physician office visit benefit. Any Copay is defined in an attached office visit Copayment Rider. If you have a Deductible, you are responsible for meeting the Deductible prior to BCN paying for Covered Services. You are required to pay the Copay at the time the Service is rendered.

Behavioral health services included in the Treatment Plan are covered the same as your PCP Benefit. Any Copay is defined in an attached office visit Copayment Rider. If you have a Deductible, you are responsible for meeting the Deductible prior to BCN paying for Covered Services. You are required to pay the Copay at the time the Service is rendered.

Outpatient Therapy Services included in the Treatment Plan are covered the same as the Referral Physician benefit. Any Copay is defined in an attached office visit Copayment Riders. If you have a Deductible, you are responsible for meeting the Deductible prior to BCN paying for Covered Services. You are required to pay the Copay at the time the Service is rendered.

Services performed pursuant to the recommended Treatment Plan will not count towards the Benefit Maximums in your Coverage including, but not limited to, visit or treatment limits imposed on speech-language pathology, physical therapy and occupational therapy.

This Coverage overrides certain exclusions as defined in this Certificate. Such exclusions include the following.

- Treatment of chronic, developmental or congenital conditions
- Learning disabilities or inherited speech abnormalities
- Treatment solely to improve cognition concentration and attentiveness
- Organizational or problem-solving skills, academic skills
- Impulse control
- Other behaviors for which behavior modification is sought when a Member is being treated for covered ASD.

Benefit Limitations

Coverage is available subject to the following requirements:

- **Preauthorization** – Services performed under the recommended Treatment Plan must be approved for payment during BCN's Preauthorization Process. If Preauthorization is not obtained, rendered services will not be covered and the Member may be held responsible for payment for those services.

- **Prior Notification** – BCN must receive prior notification of the evaluation and diagnostic assessment of the Member.

- **Providers** – All services to treat ASD must be performed by a BCN approved provider.

- **Required Diagnosis for ABA** – In order to receive Preauthorization, the Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, Participating developmental pediatrician or other professional as agreed upon by a BCN AAEC. Other

Preauthorization requirements may also apply. The requirement to be evaluated and diagnosed by an AAEC does not exist for other Services related to ASD.

- **Termination at age 19** – Benefits are limited to children up to and including the age of 18. This age limitation does not apply to Outpatient Mental Health Services (excluding ABA Services) and Services used to diagnose ASD. Benefits for ASD terminate on the child's 19th birthday.

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

Exclusions include but are not limited to

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

8.16 Physical Therapy and Rehabilitation Services

We cover short-term Outpatient physical therapy, mechanical traction and medical Rehabilitation Services, including speech therapy in full when Medically Necessary and Preauthorized by BCN.

The benefit is limited to 60 visits per Medical Episode per plan year.

8.17 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 in full 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 must be obtained 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.

NOTE: Breast pump needed to support breast-feeding is 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 the 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

8.18 Diabetic Supplies and Equipment

Basic Diabetic Supplies and Equipment, as listed below, are covered in full for the prevention and treatment of clinical diabetes if Medically Necessary when prescribed by the treating physician and obtained from a BCN Participating Provider:

- 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, must be Preauthorized by BCN and obtained from a BCN Participating Provider. Any special features that are considered Medically Necessary must be Preauthorized by BCN. Replacement of diabetic equipment is covered only when Medically Necessary.

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

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.

Exclusions include but are not limited to

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

- Alcohol and gauze pads

8.19 Prosthetics, Orthotics and Corrective Appliances

Prosthetic devices means devices that aid body functioning or replace a limb or body part after accidental or surgical loss.

Orthotic appliances mean appliances that are used to correct a defect of body form or function.

Benefits are provided only for the basic Prosthetic or Orthotic appliance and any Medically Necessary special features prescribed by a BCN Participating Physician. In addition:

- The item must be a Prosthetic or Orthotic device or appliance as defined by BCN.
- The items must be obtained from an approved BCN supplier or a Participating facility upon discharge.
- The item must be prescribed or Preauthorized by a BCN Participating Physician.
- Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.

Corrective appliances and artificial aids such as cardiac pacemakers and artificial heart valves are covered in full when Preauthorized as Medically Necessary by a BCN Participating Physician. Benefits are provided for the initial prescription lenses (eyeglasses or contact lenses) following an operation for cataract or other diseases of the eye or to replace an organic lens used during convalescence from Preauthorized eye surgery. In the case of cataract surgery, congenital absence, or aniseikonia, following the initial lenses additional prescription lenses are covered if Medically Necessary. Appliances must be obtained from a BCN approved supplier.

- Ostomy sets and accessories; catheterization equipment and urinary sets are covered.
- Burn Pressure Garments are covered when prescribed by the Member's Participating Physician to enhance healing, reduce swelling and control scarring in case of severe burns. Burn pressure garments must be obtained from a BCN approved supplier.
- Pressure Gradient Supports are covered when prescribed by the Member's Plan Physician as Medically Necessary for severe circulatory conditions, high-risk pregnancy, and post-surgical care. Pressure gradient supports must be obtained from a BCN approved supplier. Benefits are available for no more than four supports per Calendar Year, except additional supports may be covered if the Member's Participating Physician determines that they are necessary because of a significant weight gain or loss.

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.

Exclusions include but are not limited to

- Dental appliances
- Hearing aids or hearing devices
- Eyeglasses or contact lenses (except as provided in a Rider or above)
- Non-rigid appliance and supplies including but not limited to garter belts, arch supports, corsets, corrective shoes and wigs or hairpieces
- Experimental or research devices or appliances

8.20 Organ and Tissue Transplants

We cover an organ or body tissue transplant and all related services in full. The following conditions must be met:

- It is considered non-experimental in accordance with generally accepted medical practice.
- It is determined to be Medically Necessary and Preauthorized by BCN.
- Services are performed at a BCN-approved transplant Facility.

Non-experimental transplants include:

- Kidney transplants;
- Corneal transplants;
- Liver transplants for children with biliary atresia; and
- Other rare congenital abnormalities.

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

8.21 Reconstructive Surgery

Definition

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally

performed to improve function but may also be done to approximate a normal appearance. Reconstructive surgery includes:

- 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; and
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Service under this Certificate, disease, accidental injury, burns or severe inflammation including but not limited to the following procedures.
    - Blepharoplasty of upper lids
    - Panniculectomy
    - Rhinoplasty
    - Septorhinoplasty

Reconstructive surgery as defined above is covered when it is Medically Necessary and Preauthorized by BCN. Your Inpatient and Outpatient Benefit applies.

Cost Sharing

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

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

8.22 Oral Surgery

We cover oral surgery and X-rays in full when Preauthorized by BCN for the following:

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

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

NOTE: See Section 9 for additional exclusions.

8.23 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 as listed below in full 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.

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

8.24 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 in full when Medically Necessary and Preauthorized by BCN.

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

Exclusions include but are not limited to

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

8.25 Weight Reduction Procedures

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

Benefit Maximum

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

8.26 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
- The drug is ordered by a physician for the treatment of cancer
- The drug is approved by the FDA for use in cancer therapy
- The physician has obtained informed consent from the Member or their representative for use of a drug that is currently not FDA approved for that specific type of cancer
- The drug is used as part of a cancer drug regimen
- The current medical literature indicates that the drug therapy is effective, and recognized cancer organizations generally support the treatment

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; and

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

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

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

Exclusions include but are not limited to

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

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

D. Outpatient Prescription Drugs

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

8.27 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; or
- 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; or
- 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; or
- 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 when they are related to conventional treatment.
- The Experimental treatment and related Services are provided during BCN-approved clinical trial (check with your provider to determine whether a Clinical 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; or
- 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

8.28 Gender Dysphoria Treatment

Definition

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

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

Coverage

We cover Services for the treatment of Gender Dysphoria when determined to be Medically Necessary, 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 reassignment 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 within Section 8 and any attached Riders for additional 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

9.2 Services Received While a Member

We will only pay for Covered Services you receive while you are a Member and covered under the Certificate and attached Riders. A Service is considered to be received on the date 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). Once your Coverage under this Certificate ends, any attached Riders to this Certificate will automatically end without further notice by BCN.

9.3 Services that are not Medically Necessary

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

9.4 Non-Covered Services

We do not pay for these Non-Covered Services:

- Services that do not meet the terms and guidelines of this Certificate
- Office visits, exams, treatments, tests and reports for any of the following:
  - Employment
  - Insurance
  - Travel (immunizations for purposes of travel or immigration are a covered benefit);
  - Licenses and marriage license application
  - Legal proceedings such as parole, court and paternity requirement

- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Psychoanalysis and open-ended psychotherapy
- Transitional living centers such as three-quarter house or half-way house, therapeutic, boarding schools, domiciliary foster care and milieu therapies such as wilderness programs, other supportive housing, and group homes
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment
- Treatment programs that have predetermined or fixed lengths of care
- Court ordered examinations, tests, reports or treatments that do not meet requirements for Mental Health or Substance Use Disorder Coverage such as treatment of or programs for sex 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. Cosmetic surgery is not a Benefit except as specifically provided in Section 8.

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

We do not pay for Custodial Care. Custodial Care is primarily for maintaining your basic needs for food, shelter, housekeeping services, clothing and help with activities of daily living. 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 as specified in Section 8.

9.11 Elective Procedures

We do not pay for elective procedures:

- Reversal of a surgical sterilization;
- All services, supplies and medications related to Elective Abortion (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

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; and
- All services provided to non-member surrogate parents.
- Services provided to the newborn if one of the following apply:
  - The newborn's mother is not covered under this Certificate on the newborn's date of birth
  - The newborn is covered under any other health care benefit plan on their date of birth
  - The Subscriber directs BCN not to cover the newborn's services
  - Services provided to the newborn occur after the 48 or 96 hours defined under the mother'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 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.

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

9.16 Vision Service

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; and
- 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 attached BlueCard Rider for specific details on how Services are paid. It tells you what you must pay under the exclusions and limitations of this Rider.

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

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

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، ܝܢ ܚܕ ܒܪܢܫܐ ܕܩܐ ܡܗܝܪܝܬܘܢ ، ܣܢܝܩ ܠܗ ܗܝܪܬܐ، ܐܝܬܠܘܟܘܢ ܙܕܩܘܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܛܝܡܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܬܠܝܦܘܢ ܡܢܝܢܐ ܕܐܝܬܝܐ ܥܠ ܒܣܬܪܐ ܕܟܐܪܛܐ ܝܢ 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.htm*

BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

$20 OFFICE VISIT COPAYMENT RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group.

The Certificate is hereby amended to include a **$20** Copayment or 50% of the BCN Approved Amount, whichever is less, to the following services:

- Office Visits other than preventive when provided by your Primary Care Physician, BCN Participating OB/GYN for female Members or a Referral Physician when services are rendered in an office site including office visits provided at hospital locations;
- Physician visits in your home or visits by a home health agency* or;
- Outpatient therapy services.

*There is no Copayment for visits by a home health agency for BCN Medicare Advantage members.

GENERAL PROVISIONS

1. In the event a Member's coverage under the Certificate of Coverage terminates, this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

BLUE CARE NETWORK

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$100 EMERGENCY ROOM COPAY RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date indicated in notice to your Group. This Rider amends your Certificate as follows:

The Certificate is hereby amended to increase the copayment for treatment in a hospital emergency room to $100 or 50% of the cost of treatment, whichever is less. The emergency room copayment is waived, if you are admitted. All other provisions of the Certificate pertaining to emergency room care remain unchanged.

GENERAL PROVISIONS

1. In the event a Member's coverage under the Certificate of Coverage terminates or a Member becomes a conversion Subscriber, this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

BLUE CARE NETWORK

An Affiliate of
Blue Cross Blue Shield of Michigan

$20 URGENT CARE COPAY RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date indicated in notice to your Group. This Rider amends your Certificate as follows:

The Certificate is hereby amended to increase the copayment for emergency care in a non-hospital based urgent care center to $20 or 50% of the cost of treatment, whichever is less. All other provisions of the Certificate pertaining to urgent care remain unchanged.

GENERAL PROVISIONS

1. In the event a Member's coverage under the Certificate of Coverage terminates or a Member becomes a conversion Subscriber, this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

Notice: Attach this Rider to your Certificate.

BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

$6,350/$12,700 OUT-OF-POCKET MAXIMUM RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group.

This Rider amends the annual Out-of-Pocket Maximum defined in your Certificate of Coverage as set forth below. BCN covered prescription drugs and medical services apply to the Out-of-Pocket Maximum.

Out-of-Pocket Maximum amounts

- **$6,350** per individual
- **$12,700** per family (when two or more members are covered under one contract)

Exceptions

Medical and pharmacy services **not** covered by BCN and costs payable by you over the BCN Approved Amount do **not** apply to the Out-of-Pocket Maximum. For example, if you purchase a deluxe Durable Medical Equipment item at your option above the cost of the basic item, you will be responsible for the additional cost, which does not apply to the Out-of-Pocket Maximum.

GENERAL PROVISIONS

1. In the event a Member's coverage under the Certificate of Coverage terminates, this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

BLUE CARE NETWORK
An affiliate of
Blue Cross and Blue Shield of Michigan

ELECTIVE ABORTION COVERAGE RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as set forth below.

Coverage is added for first trimester elective abortion (up to the end of the 13th week of pregnancy) in each two-year period of membership.

> Cost Sharing: Covered in full for all fees associated with Facility, professional and related services. Office visit Copayment may apply if applicable.

If you have pharmacy coverage through BCN, abortion-inducing drugs are covered with the Cost Sharing defined in your Prescription Drug Rider.

If you have a Deductible, you will first be responsible for the payment of the Deductible. BCN will be responsible to make payment to the Participating Provider only after your Deductible has been paid.

GENERAL PROVISIONS

1. A monthly premium rate is charged to the Group for this Rider in addition to the premium charged for the Certificate. The applicable rate is specified on the schedule attached to the Group Agreement and the Group agrees to remit to BCN the Rider premium due, including the Subscriber contribution, if any, along with and on the same date as its regular Certificate premium.

2. In the event your coverage under the Certificate of Coverage terminates, this Rider will terminate automatically without further action or notice by BCN.

3. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

Dependent Child Eligibility Rider

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date indicated in notice to your Group. This Rider amends your Certificate as follows:

Your Coverage for Dependent Child or Dependent under a Qualified Medical Child Support Order (as defined in the Eligibility Section of your Certificate) will terminate at the end of the month in which he or she becomes 26 years old.

Note: The date of termination is determined by the Group. Please check with your Group if you have any questions about Dependent eligibility under this Rider.

All other provisions under this Certificate remain unchanged.

GENERAL PROVISIONS

1. In the event a Member's coverage under the Certificate of Coverage terminates or a Member becomes a conversion Subscriber, this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

CF11578
Language approved: 11.8.2010

BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

HEARING AID RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate of Coverage as indicated below.

DEFINITIONS

Approved Amount is the lower of the billed charge or the maximum payment level that BCN will pay for a Covered Service.

Audiologist is a professional who is licensed or legally qualified in the State of Michigan to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems. They may dispense and fit hearing aids as part of a comprehensive rehabilitative program.

Audiometric Hearing Aid Examination is a procedure to evaluate hearing and measure hearing loss. The examination includes:

- Tests for measuring hearing acuity relating to air conduction
- Bone conduction
- Speech reception threshold and speech discrimination
- Summary of findings

Binaural Hearing Aids are two electronic devices (one set) delivered on the same day worn by the patient to amplify sound and improve hearing in both ears.

Bone Anchored Hearing Aid is a bone conduction Hearing Aid composed of a titanium screw that is surgically implanted in the temporal bone behind the ear.

Conformity Evaluation Test is a follow-up visit to the physician specialist, Audiologist or Hearing Aid Dealer who prescribed the Hearing Aid to verify receipt of the prescribed Hearing Aid and evaluate its comfort, function and effectiveness. Necessary adjustments are made to assure optimal amplification and performance.

Ear Mold is a device made of soft rubber, plastic, or non-allergenic materials, vented or non-vented, that is fitted to the outer ear canal and pinna of the patient.

Hearing Aid is an electronic device worn to amplify sound and improve hearing. A conventional Hearing Aid (Monaural or Binaural) is a basic adjustable Hearing Aid

that fits inside the ear, behind the ear, or on the body. A Hearing Aid may also include a Bone Anchored Hearing Aid, if determined to be medically necessary in accordance with BCN medical policy.

Hearing Aid Dealer is a specialist who is licensed by the State of Michigan to perform:

- Audiometric Examinations,
- Hearing Aid Evaluation Tests,
- Conformity Evaluation Tests and
- to sell prescribed Hearing Aids.

Hearing Aid Evaluation Test determines what type of Hearing Aid should be prescribed to compensate for loss of hearing, based on the results of the Audiometric Exam.

Monaural Hearing Aid is a single electronic device worn to amplify sound and to improve hearing in one ear.

BENEFITS

Benefits as described in your Certificate of Coverage are amended to include Audiometric Hearing Aid Examination or Hearing Aid Evaluation, Conformity Evaluation Test and conventional Monaural Hearing Aids.

A Bone Anchored Hearing Aid is also a Covered Benefit if, in accordance with BCN medical policy, the conventional Hearing Aid does not appropriately treat a Member's medical need, and, pursuant to BCN medical necessity criteria and policy, the Bone Anchored Hearing Aid is necessary therapeutic alternative to the conventional Hearing Aid. Bone Anchored Hearing Aid must be preauthorized by BCN.

NOTE: A hearing screening performed by your Primary Care Physician is covered under your Certificate of Coverage.

Hearing care services must be authorized and performed by a Participating Provider or Participating Audiologist. The Hearing Aid must be dispensed by a Participating Provider (Hearing Aid Dealer or specialist).

Coverage is provided under this Rider only after 36 months have elapsed since the previous Audiometric Hearing Aid Examination or Hearing Aid Evaluation, Conformity Evaluation Test and the dispensing of the conventional Monaural Hearing Aid.

The Approved Amount for a conventional aid may be applied toward the price of a non-conventional aid at the Subscriber's option.

NOTE: You are responsible for any costs over the Approved Amount designated by BCN for the different type of Hearing Aid that may be prescribed or dispensed.

EXCLUSIONS

Exclusions include but not limited to:

- Binaural Hearing Aids.
- Replacement of Hearing Aids that are lost or broken, unless you have not used this benefit for at least 36 months.
- Eye-glass type Hearing Aids. Cosmetic services or equipment.
- Replacement parts including batteries, maintenance, repairs and insurance expenses for Hearing Aids.
- Hearing Aids ordered prior to the effective date of Coverage under this Rider, even if delivered after Coverage begins.
- Hearing Aids ordered prior to termination of Coverage under this Rider, but delivered after the Coverage ends.
- Charges for Audiometric Examinations, Hearing Aid Evaluation Tests, Conformity Tests and Hearing Aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the Participating Provider.
- Benefits are not provided under this Rider for medical or surgical treatment. **NOTE:** See your Member Certificate for medical coverage.
- Drugs or medications related to hearing problems.
- Examinations, tests, or Hearing Aids provided by a government agency at no cost to member.
- Charges for spare Hearing Aids.
- Hearing Aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.

- Non-prescription, non-conventional Hearing Aids and devices.

GENERAL PROVISIONS

1. A monthly premium rate is charged for this Rider in addition to the premium charged for the Certificate. The applicable rate is specified on the schedule attached to the Group Agreement and Group agrees to remit to BCN the Rider premium due, including the Subscriber contribution, if any, along with and on the same date as its regular Certificate premium.

2. In the event a Member's coverage under the Certificate of Coverage terminates, this Rider will terminate automatically without further action or notice by BCN.

3. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

BLUE CARE NETWORK

An affiliate of
Blue Cross Blue Shield of Michigan

$5/$20/$45
TIER 1/ TIER 2/ TIER 3
CUSTOM DRUG LIST
PRESCRIPTION DRUG RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as set forth below.

A. DEFINITIONS:

1. APPROVED AMOUNT is the lower of the billed charge or the sum of the drug cost plus the dispensing fee for a Covered Drug or service. The drug cost and the dispensing fee are set according to our contracts with pharmacies. The Approved Amount is not reduced by manufacturer discount programs or coupons, rebates or other credits received directly or indirectly from a drug manufacturer. Deductible, Copayment and Coinsurance that may be required of you are subtracted from the Approved Amount before we make our payment. When a Participating Pharmacy fills a prescription for a Covered Drug, we will pay the pharmacy the Approved Amount for the drug after your out- of- pocket costs.

2. BCN AFFILIATED PROVIDER means a licensed health care provider who may prescribe prescription drugs and who is: a) contracted or employed with BCN; b) a health care provider to whom a Member was referred by BCN or BCN Physician; or, c) a licensed doctor of dental surgery or doctor of dental medicine in good standing with Blue Care Network.

3. BIOLOGICAL PRODUCTS mean Prescription Drugs including biosimiliars and interchangeable biologics that are used to treat or cure disease and are manufactured in, extracted from or semi-synthesized from biological sources. Biological sources include microorganisms or plants or animal cells.

4. BRAND NAME DRUG generally means a drug that is manufactured and marketed under a registered trade name or trademark.

5. COINSURANCE means a percentage of the BCN Approved Amount you must pay for a Covered Service. Your Coinsurance is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

6. COPAYMENT means a fixed amount of the drug's Approved Amount you must pay for a covered service.

7. COVERED DRUG means a Generic Drug, Brand Name Drug or a Biological Product which is included on the Custom Drug List, that is prescribed by a BCN Affiliated Provider and **is not excluded under Section E of this Rider**. The Covered Drug is either a) obtained through a Participating Retail or Mail Order Pharmacy, or b) obtained from a Non-Participating Pharmacy in an urgent or out –of- area situation (section D2). This definition may be expanded at the discretion of BCN to include other drugs or devices that meet all of the requirements of this section.

8. CUSTOM DRUG LIST means the list of Prescription Drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee and are covered under this Rider. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require Prior Authorization and/or Step Therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a Covered Drug, or to modify the requirements for authorization of a Covered Drug. Prescription Drugs are identified according to whether they are Tier 1, Tier 2 or Tier 3 and shall be dispensed through Participating Pharmacies to Members.

9. EXCLUSIVE PHARMACY NETWORK FOR SPECIALTY DRUGS is a pharmacy network selected by BCN to provide covered Specialty Drugs to our Members. The pharmacy network agrees to accept BCN's Approved Amount as payment in full for covered Specialty Drugs.

10. EXIGENT CIRCUMSTANCES an Exigent Circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on our approved drug list.

11. GENERIC DRUGS means Prescription Drugs that contain the same active ingredients, is identical in strength and dosage form and is administered in the same way as the brand name drug. Generic Drugs are generally included in Tier 1 Generics and usually cost significantly less that the Brand Name Drug equivalent.

12. MEDICALLY NECESSARY or MEDICAL NECESSITY means a drug must be Medically Necessary to be covered, as determined by pharmacists and physicians acting for BCN, based on criteria and guidelines developed by pharmacists and physicians for BCN. The Covered Drug must be accepted as necessary and appropriate for the patient's condition and not mainly for the convenience of the Member or physician. In the absence of established criteria, Medical Necessity will be determined by pharmacists and physicians according to accepted standards and practices.

13. OFF-LABEL means the use of a drug or device for clinical indications other than those stated in the labeling approved by the Federal Food and Drug Administration.

14. OUT-OF-POCKET MAXIMUM is the highest amount of money you have to pay for covered services during the Calendar Year. Member Cost-Sharing for Prescription Drugs covered under this Rider count toward your Out-of Pocket Maximum. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to your Out-of-Pocket Maximum.

    This limit never includes:

    - Prescription Drugs not covered by BCN
    - Any difference between the cost of the Brand Name Drug and its Generic Drug or Biological Product equivalent

    If your plan includes an Out-of-Pocket Maximum, then the amount is defined in the applicable Out-of-Pocket Maximum Rider issued to you.

15. "OVER-THE-COUNTER" DRUGS means a drug that can be sold without a prescription.

16. PARTICIPATING PHARMACY means a network of licensed pharmacies selected by or authorized by BCN to provide Covered Prescription Drugs to members.

17. PARTICIPATING 90-DAY RETAIL PHARMACY means any licensed pharmacy that has an agreement with BCN to provide a 90-day supply of Covered Drugs and is not a Mail-Order Pharmacy.

18. PERSONALIZED CARE PROTOCOL PROGRAM means a program that supports Member needing enhanced coordination of care for controlled substances. Members enrolled in this program are identified by BCN. BCN will send the Member a letter 30-days before the program takes effect that explains the program's requirements and its effective date.

19. PRESCRIPTION DRUG means a medication approved by the U.S. Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a Federal legend drug).

20. PREVENTIVE MEDICATIONS are Preventive Prescription Drugs that are maintained by BCBSM/BCN based on A and B recommendations by the U.S. Preventive Services Task Force (USPSTF) and mandated under the Patient Protection and Affordable Care Act. Some BCN Preventive Medications require Preauthorization and/or Step Therapy by BCN before they are covered. The Preventive Medications may be modified as needed based on USPSTF guideline or to modify the requirements for authorization of a Covered Drug.

21. PRIOR AUTHORIZATION means obtaining BCN's advanced approval for certain Prescription Drugs before the requested drug is covered. Approval is based on whether the information that your physician provides regarding your medical condition meets BCN's clinical criteria.

22. SPECIALTY DRUGS mean Prescription Drugs that require special handling, administration or monitoring. These drugs treat complex and chronic conditions such as cancer and chronic kidney failure. BCN determines which specific drugs are considered specialty and payable through the pharmacy benefit. A list of Specialty Drugs is available at BCBSM.com.

23. STEP THERAPY PROGRAM means a program where a Member must be treated with one or more generic or preferred drugs before certain drugs are covered.

24. TIER 1 (MOSTLY GENERICS) include generic drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. Some brand name drugs may be included in Tier 1. These drugs may have a lower Copayment compared to other Tiers.

25. TIER 2 (PREFERRED BRAND) are those drugs that have a proven record for safety and effectiveness. These drugs generally are more expensive than generic drugs. Generic Drug alternatives may be available, offering more cost effective therapies.

26. TIER 3 (NON-PREFERRED BRAND) are Covered Drugs that are not included in Tier 1 or Tier 2. These drugs may have less favorable adverse effects, or their clinical value may not be as high as the Custom Drug List alternatives.

B. BENEFITS:

1. Covered Drugs
2. Injectable insulin when prescribed by a BCN Affiliated Provider
3. Specialty Drugs when obtained from a pharmacy in BCN Exclusive Pharmacy Network for Specialty Drugs
4. Disposable insulin syringes and needles
5. A and B rated preventive medications as recommended by the U.S. Preventive Services Task Force (USPSTF) and defined as preventive on the Custom Drug List.

C. COPAYMENT/COINSURANCE

Retail Prescription Drug Copayment/Coinsurance up to a 30-day maximum supply per prescription:

Note: If you have an Out-of -Pocket Maximum for pharmacy, the Out-of-Pocket Maximum amounts are defined in the applicable Riders issued to you and included with your Certificate of Coverage. Once you reach the defined Out-of-Pocket Maximum, your Covered Drugs are covered in full.

Description	Copayment/Coinsurance
Tier 1 Mostly Generics	$5 Copayment

Tier 2 Preferred Brand	$20 Copayment
Tier 3 Non-Preferred Brand	$45 Copayment
Drugs for Treatment of Sexual Dysfunction	50% Coinsurance of the BCN Approved Amount
Insulin Syringes and Needles	Applicable Tiered Copayment will apply. **Note:** A separate Copayment is not required when dispensed at the same time as insulin

Preventive Medications Retail Prescription Drug Copayment/Coinsurance up to a 30-day maximum supply per prescription:

Female Contraceptives when defined as preventive under the Custom Drug List	**Copayment**
Tier 1 Mostly Generics	Covered in full
Tier 2 Preferred Brand	$20 Copayment *
Tier 3 Non-Preferred Brand	$45 Copayment *
Preventive Medications when defined as preventive under the Custom Drug List	**Copayment**
Tier 1 Mostly Generics	Covered in full
Tier 2 Preferred Brand	Covered in full
Tier 3 Non-Preferred Brand	Covered in full
*Your cost sharing may be waived for Tier 2 and Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available. A BCN Affiliated Provider must first certify to BCN and BCN must agree that the available generic and preferred drug alternatives are ineffective or pose unnecessary risk to you. In such instances, the cost sharing is waived only if the preventive medication is dispensed by a Participating Pharmacy and the request for coverage is approved by BCN.	

90-day Retail Prescription Drug Copayment when dispensed by a Participating 90-Day Retail Pharmacy:

Description	**Copayment/Coinsurance**
84-90 day supply of maintenance drugs **Note:** Specialty Drugs are limited to a 30 day supply.	2 times the applicable tiered Copayment

D. LIMITATIONS:

1. Prescriptions for Covered Drugs are limited to a 30-day retail supply except that BCN in its discretion may recognize for benefit purposes the provision of specific prescription drugs in quantities exceeding a 30-day supply. BCN retains the right to place a lower maximum supply limit on certain Covered Drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g. inhalers). This Rider does not cover any prescription refill in excess of the number specified by

the physician or any prescription or refill dispensed after the date the prescription has expired. In addition, BCN may set quantity limits based on clinical appropriateness and manufacturer recommended dosing for particular drugs.

Note: BCN reserves the right to limit the quantity of select Specialty Drugs to a 15- day supply. Your Copayment will be reduced by fifty percent (50%) for the 15- day supply.

2. BCN will reimburse a Member the amount specified on BCN's fee schedule or Member's actual charge, whichever is less, minus the Copayment, if a Member obtains Covered Drugs, needles and syringes, or insulin from a non-participating pharmacy in an urgent situation or when a Member is out-of-area and a Participating Pharmacy is not available.

3. USPSTF A and B rated preventive medications and devices are covered under this Rider only when obtained from Participating Pharmacies and with a valid prescription from Affiliated Providers. Prior Authorization, Step Therapy and quantity limits may apply.

4. Included in the Custom Drug List Covered Drugs that are benefits under this Rider only if a BCN Affiliated Provider certifies to BCN and BCN agrees that the Covered Drug in question is medically necessary for the Member, based on BCN's approved criteria. Those Covered Drugs are not payable by BCN without Prior Authorization by BCN.

5. Some drugs require step therapy before the prescribed drug is covered. These drugs require a previous trial with one or more preferred drugs before coverage is provided.

6. Certain drugs are not covered unless your BCN Affiliated Provider first certifies to BCN and BCN agrees that the available generic and preferred drug alternatives are ineffective or pose unnecessary risk to you. In such instances, the request for coverage must be approved by BCN and the highest Tier Copayment will apply.

7. If a Member obtains a Brand Name Drug when a Generic Drug or Biological Product equivalent is on the Custom Drug list, the Member must pay the difference between the cost of the Brand Name Drug and the cost of its Generic Drug or Biological Product equivalent, in addition to the applicable brand Copayment or Coinsurance. The Member will not be required to pay the difference between the Brand Name Drug and its Generic Drug or Biological Product equivalent if the physician receives prior approval based on medical necessity from BCN to designate the prescription "Dispense as Written" and the Brand Name Drug is dispensed. The difference in cost between the Brand Name Drug and its Generic or Biological Product equivalent does not apply to the Out-of-Pocket Maximum, if applicable.

8. For Member enrolled in the Personalized Care Protocol Program, the controlled substance is only covered when prescribed by a BCN approved Affiliated Provider and dispensed by a BCN approved Participating Pharmacy. If a Member cannot meet

these requirements, such as when they are travelling, the controlled substance will be covered only if BCN approves the prescribing provider and the pharmacy before a controlled substance is dispensed.

Note: Only controlled substances fall under this program. For all other Covered Drugs, Members can go to a BCN Affiliated Provider or Participating Pharmacy of their choice.

E. EXCLUSIONS:

There is no coverage under this Rider for:

1. Covered Drugs, needles and syringes, or insulin provided by any private or public agency, which are or may be obtained by the Member without cost to the Member.

2. Any drug which is experimental or which is being used for experimental purposes including, but not limited to, those regarded by the U.S. Food and Drug Administration as investigational.

3. Any prescription which is filled after termination of this Rider or which is filled prior to termination of this Rider but provides more than a 30-day supply of a Covered Drug beyond the termination date.

4. Any cosmetic drug or drug used for cosmetic purposes. "Cosmetic drug" or "cosmetic purpose" means any prescription legend drug which is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting hair growth, reducing or eliminating wrinkles or altering the appearance, and any substance intended to be used as a component of the above drugs.

5. Prescription drugs ordered for or dispensed to a Member when the drug is part of and included in a benefit under the Member's Certificate. Coverage for such drugs, including vaccines, serums and drugs for treatment of infertility, are subject to the benefits, limitations, exclusions and Copayment/Coinsurance requirements of the Member's Certificate.

6. Specialty Drugs obtained from any pharmacy not in our Exclusive Pharmacy Network for Specialty Drugs. BCN has contracted with our Exclusive Pharmacy Network for Specialty Drugs to provide your Specialty Drugs. Contact Customer Service for the location nearest you. If you obtain your Specialty Drugs from any other pharmacy, you may be responsible for the total cost.

7. Any Prescription Drug, insulin, or needles and syringes to the extent that benefits or coverage are available under Medicare or under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

8. Any drug, needles or insulin that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or prescribed for the Member in accordance with generally accepted professional procedures.

9. Prescription Drugs for which there is an Over- The- Counter equivalent in both strength and dosage form.

10. Over-the-Counter drugs unless coverage is required under the Patient Protection and Affordable Care Act.

11. Replacement prescriptions resulting from loss, theft, or mishandling.

12. Prescription drugs that are compounded that do not meet all of the following criteria:
    a) contain at least one active ingredient for which the FDA requires a prescription to obtain the prescribed strength and dose form;
    b) all medications used are approved by the FDA and covered by BCN;
    c) none of the medications is a bulk powder;
    d) none of the medication is included on the list of drugs specifically excluded at BCN from coverage for compounded products;
    e) medications are prepared for administration in the same manner approved by the FDA (i.e. oral, injection, topical cream);
    f) are submitted by a Participating Pharmacy using the NDC number (product identifier code) assigned by the manufacturer or distributor to the active ingredient (s); and
    g) are not being used for experimental and investigational purposes (as previously defined in this Rider).

13. "Rx only" labeled therapeutic devices or appliances, regardless of the reason they were prescribed.

14. Drugs that are not approved by the Federal Food and Drug Administration except for insulin or such drugs that BCN designates as covered.

15. Any drug or device prescribed for use or dosage other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the Off-Label use of a drug or device. However, BCN will pay for such drugs and the reasonable cost of supplies needed to administer them as defined in the BCN off-label drug use policy, if the prescribing provider can substantiate that the drug is recognized for treatment of a condition for which it was prescribed.

16. Any drugs not reviewed and recommended by BCN for addition to the Custom Drug List.

17. Prescription Drug prescriptions written by a provider who is sanctioned at the time the prescription is dispensed. The provider can be sanctioned by the Office of the Inspector General, State of Michigan or BCN.

18. The use, medical or otherwise, of marijuana (cannabis).

19. Drugs not yet approved by the BCBSM/BCN Pharmacy and Therapeutics Committee.

20. Hormonal therapy drugs for the treatment of idiopathic short stature, regardless of height percentile and growth speed.

F. GENERAL PROVISIONS:

1. You, your designee, or the provider may request an expedited review in an event your Prescription Drug is not on the Custom Drug List. BCN must Prior Authorize coverage of such Prescription Drug before it is dispensed. If Prior Authorization is not obtained for a drug not on the Custom Drug List before it's dispensed, the drug will not be covered.

   To request BCN's approval, you, your designee, or the prescribing provider or the provider's designee should contact us and follow our exception request process.

   For expedited requests due to Exigent Circumstances:
   We will notify the person making the request of our decision (either approval or denial) within 24 hours from the receipt of the request.

   For requests that are not due to Exigent Circumstances:
   If your request is not an Exigent Circumstance, we will notify you of our decision within 72 from the receipt of the request.

   If we approve the exception request, you will have to pay your Deductibles, Coinsurances or Copayments.

   If your request is based on Exigent Circumstances, the prescribing provider or other prescriber **must submit** an oral or written statement that:
   - An exigency exists,
   - The reason for the exigency,
   - Why the Member must have the requested drug, including statement that all other drugs on the Custom Drug List:
     - will be or have been ineffective,
     - would not be as effective as the requested drug, or
     - would have an adverse effect on the Member

Only FDA-approved drugs are eligible for an exception. Of those drugs, BCN will only approve the drugs that meet our clinical criteria and are effective in treating your condition.

If Prior Authorization is not obtained before the drug is dispensed, the drug will not be covered. If the exception request is Prior Authorized, the applicable Non-Preferred Cost Sharing tier will apply.

To learn more about this process, visit www.bcbsm.com or call the Customer Service number on the back of your ID card.

2. Until further notice, all terms, limitations, exclusions and conditions of the Member Certificate remain unchanged except as provided in this Rider.

BLUE CARE NETWORK

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MAIL-ORDER PRESCRIPTION DRUG RIDER 1X

This Rider is issued to you in connection with your Prescription Drug Rider and your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Prescription Drug Rider by defining the Copayment for each Covered Drug obtained from Participating Mail-Order Pharmacies.

A. DEFINITIONS

1. MAIL-ORDER PRESCRIPTION DRUG means a Generic, Brand Name Drug or a Biological Product which is: a) prescribed by a BCN Affiliated Provider; and b) obtained through a Participating Mail-Order pharmacy, **except as excluded in your group's Prescription Drug Rider.** This definition may be expanded at the discretion of BCN to include other drugs and devices that meet all other requirements of your Prescription Drug Rider.

2. NON-PARTICIPATING MAIL-ORDER PHARMACY means a pharmacy that does not have an agreement with BCN to provide Covered Drugs through the Mail-Order Prescription Drug Pharmacy. Non-Participating Mail-Order Pharmacies have not agreed to accept the Approved Amount as payment in full for Covered Prescriptions Drugs. BCN will not pay for drugs obtained from Non-Participating Mail-Order Pharmacy.

3. PARTICIPATING MAIL-ORDER PHARMACY means a pharmacy that has an agreement with BCN to provide Covered Drugs through the Mail-Order Prescription Drug Pharmacy. Participating Mail-Order Pharmacies have agreed to accept the Approved Amount as payment in full for Covered Prescription Drugs when provided to Members.

B. BENEFITS

BCN will pay for most Covered Drugs and each refill when dispensed through a BCN Participating Mail-Order Pharmacy.

Note:

- **Certain Covered Drugs are limited to a 30-day supply.**
- **Some Covered Drugs may not be available through a Participating Mail-Order Pharmacy.**

C. COPAYMENT

Your Mail-Order Copayment is as follows:

Prescription Drugs with a 31–90 day supply dispensed by a Participating Mail-Order Pharmacy

- The Copayment for Prescription Drugs with a 31-90 day supply through Mail-Order services is the same Copay as a 30-day supply at a Retail Pharmacy.

Note: If you have a Coinsurance, your Coinsurance will be based on the BCN Approved Amount for the quantity dispensed. If your Coinsurance includes a minimum and maximum Copayment, the minimum and maximum amounts remain the same. If you have a pharmacy Deductible, you are responsible for meeting the Deductible prior to BCN paying for Covered Services.

D. EXCLUSIONS

1. Mail-Order Prescriptions for Specialty Drugs may only be obtained from the Exclusive Pharmacy Network for Specialty Drugs. Information about the Exclusive Pharmacy Network for Specialty Drugs is available at www.BCBSM.com

2. All limitations and exclusions detailed in your BCN Prescription Drug Rider remains unchanged and are applicable to the Participating BCN Mail-Order Prescription Drug Program.

3. There is no coverage for any prescription for more than a 90-day supply of a Covered Drug obtained from a Participating Mail-Order Pharmacy.

4. There is no coverage for drugs obtained from a Non-Participating Mail-Order Pharmacy.

All other provisions in your Certificate and Prescription Drug Riders remain unchanged.

BLUE CARE NETWORK

An affiliate of
Blue Cross and Blue Shield of Michigan

DOMESTIC PARTNER RIDER
(Same and Opposite Gender)
INCLUDING DEPENDENT CHILDREN

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date adopted by your Group. This Rider amends your Certificate as follows:

1. An adult same or opposite gender Domestic Partner of the Subscriber is eligible for Membership as a Domestic Partner under the Certificate of Coverage if all of the following conditions are met:

   a) Both partners are 18 years of age or older;

   b) The parties are not related by blood in a manner that would prohibit legal marriage;

   c) Neither the Subscriber nor the Domestic Partner was legally married on the date they enrolled for Coverage under this Rider.

   d) The Subscriber and Domestic Partner are each other's sole Domestic Partner, intend to reside together permanently and have resided together for at least twelve consecutive months prior to enrollment in Blue Care Network.

      NOTE: Shared residency may be established by:
      - Driver's license
      - Voter registration
      - Student identification
      - City or county registration
      - Rental or mortgage agreement
      - Other certain document

   e.) The Subscriber's employer gives BCN a signed and notarized Affidavit of Domestic Partnership along with the Subscriber's application.

2. The children of Subscriber's Domestic Partner are eligible for Coverage under the Subscriber's contract. They are covered through the end of the Calendar Year in which they turn age 26.

   a) The children must be related to the Domestic Partner by:
      - Birth
      - Legal adoption or

- Legal guardianship

The following are not eligible for Coverage under the Subscriber's contract:
- The spouse of a Domestic Partner's child
- The grandchildren of the Domestic Partner (unless eligible under legal guardianship)

b) Disabled, unmarried children of the Subscriber's Domestic Partner may remain on the Subscriber's contract after the end of the Calendar Year in which they turn age 26 if all of the following apply:

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

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

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

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

3. This Rider shall terminate automatically at any time the Domestic Partner ceases to meet the eligibility standards of Paragraph 1 above or at any time Coverage of the Subscriber terminates under the Certificate.

4. The Subscriber agrees to notify its Group and BCN within 31 days of any change in eligibility status of any Domestic Partner covered under this Rider. The Subscriber and Domestic Partner will be responsible for reasonable charges for any Services or Benefits provided under the Certificate of Coverage after the Domestic Partner ceases to be eligible for Coverage pursuant to the terms of this Rider.

EFFECTIVE DATE

Coverage takes effect 90-days after the date that the application is approved. However, BCN will waive the 90-day waiting period in the following situations:

- In instances where the Domestic Partner (or the Domestic Partner and his or her children) had Coverage with the Group's former insurer, BCN will waive the 90-day waiting period at the initial enrollment of the Group, if all of the following conditions are met:

- The Domestic Partner can demonstrate that he or she (or the Domestic Partner and his or her children) had Coverage under the Group's prior health insurance carrier for at least 90-days prior to the effective date of the BCN Coverage.
- The Group waives the 90-day waiting period.
- The Domestic Partner (or the Domestic Partner and his or her children) meets all other eligibility requirements in this Rider, including the completion of a signed and notarized Affidavit of Domestic Partnership.
- The application for Coverage submitted by the Group includes documentation that all of the above are met.

NOTE: The waiver only applies to Domestic Partnerships that exist when BCN Coverage becomes effective. Domestic Partnerships that occur after the effective date of the BCN Coverage will be subject to the 90-day waiting period, along with all other provisions of this Rider.

- In instances where the Domestic Partner (or the Domestic Partner and his or her children) has lost eligibility for Coverage under another health care plan, BCN will comply with special enrollment requirements in the Health Insurance Portability and Accountability Act and waive the 90-day waiting period if the following conditions are met:

  - The application submitted to BCN by the Group must include a letter or other documentation from the Domestic Partner's former employer or insurance carrier verifying that the Domestic Partner is no longer eligible for Coverage.
  - The Domestic Partner (or the Domestic Partner and his or her children) must meet all other eligibility requirements in this Rider, including completion of a signed and notarized Affidavit of Domestic Partnership.

CHANGES IN YOUR FAMILY

For additional eligibility criteria, please refer to General Provisions chapter within your Certificate of Coverage.

LIMITATIONS AND EXCLUSIONS

- Only one Domestic Partner may be covered under a Subscriber's contract at one time.
- The Domestic Partner's Coverage will end if the partnership ends.
- Coverage for children of the Domestic Partner will end if the partnership ends.
- Children of the Domestic Partner will not be covered unless the Domestic Partner is covered under the Subscriber's contract.
- Coverage for the Domestic Partner and his or her children will end if the Subscriber's coverage ends.

- Coverage will end if any statement in the Affidavit of Domestic Partnership or any other documents given to us is false when it is submitted or becomes false after that.

- Domestic Partners are not eligible for surviving spouse Coverage when this option is available under the Subscriber's contract.

GENERAL PROVISIONS

1. In the event a Member's Coverage under the Certificate of Coverage terminates this Rider will terminate automatically without further action or notice by BCN.

2. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

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SPONSORED DEPENDENT RIDER

This Rider is issued to you in connection with your Certificate of Coverage. It is effective on the date indicated in notice to your Group. This Rider amends your Certificate as follows:

1. An adult family member of a Subscriber is eligible for membership as a sponsored dependent under the Certificate of Coverage if all of the following conditions are met:

    a) The person is over 25 years of age if he or she is a child, as that term is defined in the Certificate, or the person is over 19 years of age, not a child, as defined by the Certificate but is otherwise related to the Subscriber by blood or marriage within the terms of the Internal Revenue Code of the United States for dependents; and

    b) The person qualified as a dependent on the Subscriber's last tax return filed under the Internal Revenue Code of the United States; and

    c) The person is currently receiving more than one half of his or her support from the Subscriber; and

    d) The person resides in the Subscriber's household; and

    e) The person is not enrolled or eligible to enroll in Medicare or Medicaid.

2. The Subscriber shall be required to furnish to BCN annually proof of eligibility for a sponsored dependent.

3. This Rider shall terminate automatically at any time the sponsored dependent ceases to meet the eligibility standards of Paragraph 1 above or at any time coverage of the Subscriber terminates under the Certificate.

4. The Subscriber agrees to notify its Group and BCN within 30 days of any change in eligibility status of any sponsored dependent covered under this Rider. The Subscriber and sponsored dependent will be responsible for reasonable charges for any services or benefits provided under this Rider. The Subscriber and sponsored dependent will be responsible for reasonable charges for any services or benefits provided under this Certificate after the sponsored dependent ceases to be eligible for coverage pursuant to the terms of this rider.

GENERAL PROVISIONS

1. A monthly premium rate is charged for this Rider in addition to the premium charged for the Certificate. The applicable rate is specified on the schedule attached to the Group Agreement and the Group agrees to remit to BCN the Rider premium due, including the Subscriber contribution, if any, along with and on the same date as its regular Certificate premium.

2. In the event a Member's coverage under the Certificate of Coverage terminates or a Member becomes a conversion Subscriber, this Rider will terminate automatically without further action or notice by BCN.

3. Until further notice, all terms, limitations, exclusions, and conditions of the Certificate of Coverage remain unchanged except as provided in this Rider.

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BLUECARD® PROGRAM ADDENDUM

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

Your Certificate is amended to include the following:

Out-of-Area Services

Overview

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

Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCN remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and

those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCN to provide the specific service or services.

A. BlueCard® Program

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

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

Liability Calculation Method Per Claim

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

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

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

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

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

The Host Blue determines whether or not it will use an actual price, an estimated price or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the

Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

B. Nonparticipating Providers Outside of the BCN Service Area

1. Member Liability Calculation

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

2. Exceptions

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

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

C. Blue Cross Blue Shield Global® Core

General Information

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

Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- **Inpatient Services**

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

- **Outpatient Services**

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

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

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. The claim form is available from BCN, the service center or online at www.bcbsglobalcore.com. If you need assistance with the claim submissions, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

D. Exclusions and Limitations

This addendum will not apply if:

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

E. General Information

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

- Until further notice, all the terms, definitions, limitations, exclusions and conditions of your Certificate and related Riders remain unchanged.

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Tell us what you think. Your opinions matter to BCN and help us improve how we serve our members. Please take a moment to share your thoughts about your enrollment experience. You can also take our online survey at **bcbsm.com/bcnfeedback.**

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Before enrolling, I received accurate information about BCN benefits.	☐	☐	☐	☐	☐
The member handbook helps me understand my benefits.	☐	☐	☐	☐	☐
I am satisfied with the BCN enrollment process.	☐	☐	☐	☐	☐
My early impression of BCN is favorable.	☐	☐	☐	☐	☐

Name: _____

Address: _____

City, State ZIP code: _____

How could we have better met your needs during the enrollment experience?

_____

_____

Thank you for your feedback.

BCN HMO
R027302

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Customer Service

1-800-662-6667
711 (TTY users)

8 a.m. to 5:30 p.m.
Monday through Friday