

Michigan State University
Graduate Assistant Plan
Benefit Document



BENEFIT DOCUMENT

BCN Service Company A licensed third party administrator

This document describes the Benefits provided under your Coverage and may be amended at any time, upon mutual agreement between Michigan State University ("MSU"), Group Health Plan and BCN Service Company ("BCNSC").

BCNSC is a licensed third party administrator ("TPA") and independent licensee of the Blue Cross® Blue Shield® Association ("BCBSA"). BCNSC's license with BCBSA permits BCNSC to use the Blue Cross® Blue Shield® Service Marks in Michigan. BCNSC is a Michigan nonprofit corporation and a wholly owned subsidiary of Blue Care Network of Michigan ("BCN").

BCNSC administers the benefit plan for MSU and provides administrative claims payment services only. BCNSC does not insure the coverage nor do we assume any financial risk or obligation with respect to claims.

The General Provisions and Your Benefits chapters describe the Benefits provided under your Coverage in accordance with the Administrative Service Agreement ("ASC").

By choosing to enroll as a BCNSC Member, you agree to abide by the rules as stated in the General Provisions and Your Benefits chapters of this book.

Please read these documents carefully and keep them with your personal records for future reference. MSU reserves the right to interpret and resolve conflicts between any statements in this Benefit Document that conflict with MSU booklets, summaries or other benefit related documents.

Blue Care Network of Michigan (BCN)

BCNSC has contracted with BCN to provide certain administrative services to support your Coverage. This means that, among other things, BCN will provide customer service, as well as Preauthorizations and disease management programs. Your BCNSC ID card lists BCN phone numbers that you or your health care provider may need to contact.

Definitions

These definitions will help you understand the terms used in this booklet. **Other** terms are defined later as necessary.

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

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

Amendment is a change to the Benefit Document (addition, deletion, or revision) that is requested by the Group and Group Health Plan. When there is a conflict between the Benefit Document and the Amendment, the Amendment takes precedence.

Approved Amount also known as the Allowed Amount is the lower of the billed charge or the maximum payment level BCNSC will pay for the Covered Services. Deductibles, Copayments and Coinsurance that may be required of you are subtracted from the Approved Amount before we make our payment.

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

BCN Network Participating Provider is an individual, Facility or other health care entity that has contracted with BCN/BCNSC to provide you with Covered Health Services and has agreed not to seek payment from you for Covered Services except for applicable Deductible, Copayments, and/or Coinsurance.

BCN Service Company (BCNSC) is a licensed third party administrator that will administer Coverage.

Balance Billing, sometimes called extra billing, occurs when a provider bills you for the difference between their charge and the Approved Amount. A Participating Provider may not Balance Bill you for Covered Services. A non-Participating Provider may Balance Bill you for charges and you will be responsible for those charges.

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

Benefit Document is this booklet that describes the Covered Health Services available to you.

Blue Care Network (BCN) is a Michigan Health Maintenance Organization that has contracted with BCNSC to provide certain administrative services to support your Coverage described in this Benefit Document.

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

Cognitive Rehabilitation Therapy (“CRT”) is the process of relearning Cognitive Skills that have been lost or altered as a result of damage to brain cells/chemistry. If skills cannot be relearned, then new ones have to be taught. CRT teaches us how to compensate for these lost cognitive functions.

Cognitive Skills are the core skills we use to think, read, learn, remember, reason, and pay attention. Working together, they take incoming information and move it into the bank of knowledge we use every day at school, at work, and in life.

Coinsurance is your share of the costs of a Covered Service calculated as a percentage of the BCNSC 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 an Amendment is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

Continuity of Care is when a Member chooses, in certain circumstances, to continue receiving services from a physician who no longer contracts with BCNSC.

Contract Holder is the eligible person who has enrolled for BCNSC Benefits or an individual continuing BCNSC Coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time (“COBRA”). The Contract Holder is the person whose relationship to the Group is the basis for Medical Benefit Plan eligibility. This person is also referred to as the “Member”.

Coordination of Benefits (COB) means a process of determining which benefit document or policy is responsible for paying Benefits for Covered Services first (primary plan). When you have dual coverage, this allows the secondary plan to reduce its Benefits, so that the combined Benefits of all plans do not exceed the total allowable fees. 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 the 100% of the total allowable amount to which you, as the Member, or the provider is entitled.

Copayment (Copay) is a fixed dollar amount you owe for certain Covered Services. The Copay is due at the time the Service is rendered. Copay amounts might be different for different health care services. For example, your Emergency room Copay might be higher than your office visit Copay. Copays apply toward the Out-of-Pocket Maximum.

Cosmetic Procedures are procedures or services that change or improve appearance without significantly improving physiological function, as determined by BCN.

Cost Sharing (Deductible, Copayment and/or Coinsurance) is the portion of health care costs you owe as defined in this Benefit Document and any attached Amendments. BCNSC pays the balance of the Allowed Amount for Covered Services.

Coverage(s) means the benefit programs under the Group Health Plan for which BCNSC will be processing claims and providing other administrative services in support of Covered Services.

Coverage Period or Plan Year is the period designated by MSU and BCNSC. It begins on the date as determined by MSU and BCNSC. Please check www.hr.msu.edu for Coverage Period/Plan Year dates.

Covered Health Services or Coverage are those Medically Necessary services, drugs or supplies provided in accordance with and identified as payable under the terms of this Benefit Document.

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. Custodial Care can be provided safely and reasonably by people without professional skills or training. Custodial Care is not covered.

Deductible is the amount that you owe for health care services before BCNSC pays. 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 revised when an Amendment is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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

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

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

Group is Michigan State University.

Group Health Plan means the medical Benefits plan provided by MSU.

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

Hospital is a state-licensed, 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 where you occupy a Hospital bed while receiving Hospital care including room and board and general nursing care. It may occur after a period of Observation Care.

Inpatient Service/Stay is an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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, which is distinct from the patient's usual state of health, and has a defined beginning and course over a period of time. 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, which makes the Member unable to walk at all. The acute flare-up would have a distinct beginning and would run a distinct length of time, finally reverting 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
- Not primarily for the convenience of the Member or health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease
- Not regarded as experimental by BCN
- Rendered in accordance with BCN Utilization Management Criteria for Mental Health and Substance Use Disorders

Member (or you) means the Contract Holder or an eligible dependent entitled, under the terms of the Group Health Plan, to receive Coverage.

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.

MSU Health Team is the multi-specialty medical practice comprised of teaching faculty from MSU's College of Medicine, College of Osteopathic Medicine, and College of Nursing. MSU Health Team offers primary and specialty health care services to the general public. It is comprised of approximately 200 physicians and nurse practitioners from 14 clinical departments as well as many allied health professionals.

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

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

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

Out-of-Pocket Maximum is the most you have to pay for Covered Services during a Plan Year. The Out-of-Pocket Maximum includes your medical Deductible, Copayment and Coinsurance. This limit never includes your premium, Balance Billed charges, pediatric dental, pediatric vision or health care services that BCNSC does not cover.

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.

Pediatric Member is a child ranging from date of birth up to 17 years of age. Pediatric Members are not eligible to be seen at SHS at Olin Health Center. Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of SHS at Olin Health Center.

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

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 Student Health Services (SHS) at Olin Health Center. You will be assigned an Olin Health Center physician who will provide and coordinate your medical health care including specialty Referrals and Hospital care.

Professional Services are services performed by a licensed professional, which include but not limited to:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathic Medicine (D.O.)
- Doctor of Podiatric Medicine (D.P.M.)
- Licensed Psychologist (L.P.)
- Certified Nurse Midwife (C.N.M.)
- Board Certified Behavior Analyst (B.C.B.A.)
- Doctor of Chiropractic (D.C.)
- Physician Assistant (P.A.)
- Certified Nurse Practitioner (C.N.P.)
- Licensed Professional Counselor (L.P.C.)
- Licensed Master Social Worker (L.M.S.W.)

Referral is required from MSU Student Health Services at Olin Health Center if you seek care from a BCN Network provider that is located within a 45 miles radius of Olin Health Center. Benefits will not be paid for care received from a BCN Network provider located within 45 miles of Olin Health Center without a Referral. You must begin treatment at Olin Health Center for Benefits to be paid. A Referral is required for each separate medical condition. A new Referral is needed each Plan Year for continuing treatment.

NOTE: Additional information is found in Section 8 Your Benefits-Important Information in this

Benefit Document.

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

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

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

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 the geographic area in Michigan in which BCNSC does business. The majority of our BCNSC 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, and/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 the medically desired result; and
- Are ordered by the attending physician; and
- Are Medically Necessary according to generally accepted medical standards.

Examples include, but are not limited to, intravenous medication administration, complex wound care, and Rehabilitation Services. Skilled Care does not include private duty or hourly nursing, Respite Care, or other supportive or personal care services such as administration of routine medications, eye drops and ointments.

Skilled Nursing Facility is a state-licensed, 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.

Student Health Services (SHS) at Olin Health Center is the Michigan State University's primary on-campus health facility. Medical Services are provided by board-certified physicians and other certified medical professionals.

Urgent Care Center is a Facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, illness or injury, or the onset of Acute or severe symptoms.

Your Benefits is a chapter in this document that provides a detailed description of health care Coverage, including exclusions and limitations.

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CHAPTER 1 - GENERAL PROVISIONS

Section 1: Eligibility

1.1 Eligibility

Michigan State University (MSU) is responsible for determining eligibility. BCNSC does not make eligibility determinations, but updates its files to record eligibility information provided by MSU.

Please contact MSU Human Resources at (800)353-4434 or (517)353-4434 for eligibility information.

1.2 Additional Eligibility Guidelines

The following guidelines apply to all Members:

- **Medicare:** If you become eligible to enroll in Medicare, you will only be eligible for the Medicare complementary program **except** when Medicare is the secondary payer by law.
- **Change of Status:** You agree to notify Group Health Plan within 30 days of any change in eligibility status of you or any family dependents. When you are no longer eligible for Coverage, you are responsible for payment for any services or Benefits unless the services are covered under other health benefit plan or insurance.
- If you are admitted to a Hospital or Skilled Nursing Facility prior to the effective date of this Benefit Document you will be covered for Inpatient care on the effective date of Coverage only if:
 - You have no continuing coverage under any other health Benefits contract, program or insurance;
 - BCNSC or BCN authorizes inpatient care as Medically Necessary upon notification of admission; and
 - Your medical management is transferred to your Primary Care Physician before or on the effective date.

Section 2: Other Party Liability

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

- Are not Preauthorized by BCN; or
- Are not Covered Services under this Benefit Document.

It is your responsibility to provide complete and accurate information 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

- BCNSC Coverage provides you with Benefits for health care services as described in this Benefit Document.

- BCNSC does not duplicate Benefits or pay more for Covered Health Services than the actual fees.
- Coverage described in this Benefit Document will be reduced to the extent that the services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for the payment under such health plan or policy.

2.2 Auto Policy and Worker's Compensation Claims

- This Benefit Document is a coordinated Certificate of Coverage. This means that for medical care needed as the result of an automobile accident, if the Member has a coordinated no-fault insurance policy, then BCNSC will assume primary liability for Covered Services. The no-fault automobile insurance would be secondary.
- If the Member has coverage through a non-coordinated (sometimes called a “full medical”) no-fault automobile insurance policy, then the automobile insurance will be considered the primary plan. BCNSC would pay Coverage under this Benefit Document as the secondary plan.
- If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member's medical services. BCNSC would provide for Covered Services under this Benefit Document as the secondary plan.
- If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. BCNSC would pay for Covered Services under this Benefit Document as the secondary plan.
- If the motorcycle insurance does not provide medical coverage or if medical coverage is exhausted, then BCNSC will pay for Covered Services under this Benefit Document as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCNSC will pay secondary.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers' compensation program will not be paid under Coverage.
- If any such services are paid or provided by BCNSC, BCNSC has the right to seek reimbursement on behalf of the Group Health Plan from the other program, insurer or Member who has received reimbursement.
- BCNSC authorization requirements must always be followed for auto or work-related injuries in order for them to be paid under Coverage.

2.3 Coordination of Benefits (COB)

We coordinate Benefits payable under this Benefit Document 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 BCNSC Coverage.

After those benefits are determined, your BCNSC 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 BCNSC 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 BCNSC 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 BCNSC.

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

"Claim 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 the 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 BCNSC paid on behalf of the injured person.

"Common Fund Doctrine" is a legal doctrine that requires BCNSC 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; or
- ◆ 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 BCNSC paid as a result of plaintiff's injuries.

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

"Other Equitable Distribution Principles" means any legal or equitable doctrines, rules, laws or statutes that may reduce or eliminate all or part of BCNSC'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, BCNSC may have paid for health care services for you that were or should have been paid by another person, insurance company or organization. In these cases:
 - You assign to us your right to recover what BCNSC paid for your medical expenses for the purpose of subrogation. You grant BCNSC 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 BCNSC when your medical expenses should have been paid by another party but was not due to an act or omission.
 - You agree to inform BCNSC when you hire an attorney to represent you, and to inform your attorney of BCNSC's right and your obligations under this Benefit Document.
 - You must do whatever is reasonably necessary to help BCNSC 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 a written consent from BCNSC if payment was made for the treatment you received for that injury.
 - You agree to cooperate with BCNSC in the efforts to recover money paid on your behalf.
 - You acknowledge and agree that this Benefit Document supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.

Section 3: Member Rights and Responsibilities

3.1 Confidentiality of Health Care Records

Your health care records will be kept confidential by BCNSC, its agents and the providers who treat you in accordance with state and federal privacy laws.

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

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

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

3.3 Primary Care Physician

Olin Health Center is your designated Primary Care Provider.

Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of SHS at Olin Health Center. 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 in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetric and gynecologic care. The Participating specialist, however, may be required to comply with certain BCN procedures, including obtaining Preauthorization for certain Services, following a pre-approved treatment plan, or procedures for making Referrals. The female Member retains the right to receive the obstetrical and/or gynecological Services directly from her Primary Care Physician.

For information on how to select a Primary Care Physician for Pediatric Members, and for a list of Participating Primary Care Physicians, Participating pediatricians and Participating health care professionals who specialize in obstetrics and gynecology contact Customer Service at 1-800-662-6667 or on-line at www.bcbsm.com.

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

3.4 Refusal to Accept Treatment

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

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

3.5 Complaint and Grievance Procedure

If you have a complaint or grievance regarding any aspect of the services received that is not

resolved to your satisfaction, you must follow the formal grievance procedure. You have two years from the date of discovery of a problem to file a grievance or appeal a decision of BCNSC. There are no fees or costs.

To submit a standard grievance, you or someone authorized by you in writing, must submit a statement of the problem in writing to:

Appeals and Grievance Unit – Mail Code C248
Blue Care Network
P. O. Box 284
Southfield, MI 48086-5043
Fax: 888-458-0716 (until 12/31/16)
866-522-7345 (new 1/1/17)

Step One

BCNSC will review your concern and reply within 15 calendar days for pre-service claims and within 20 calendar days for post-service claims. If you disagree with our decision, you may appeal to Step Two within 180 calendar days after receiving BCNSC's decision. The individuals who review the first-level appeal are not the same ones involved in the initial decision. If your appeal is denied, BCNSC will write to you and explain the reasons for the denial and next steps in grievance process. At your request and at no charge to you, BCNSC will provide all documents and records used in making the decision.

Step Two: Review and decision by a BCNSC Grievance Panel

If you appeal from Step One, BCNSC's Member Grievance Panel will review the decision made at Step One. You must file an appeal within 180 calendar days of your receipt of the adverse Step One decision. For pre-service and post-service claims, you will be notified of the Step Two grievance decision within 15 calendar days.

If BCNSC fails to provide a final decision within 30 calendar days for pre-service or 35 calendar days for post-service claims (plus 10 business days if we ask for additional medical information) from the date we receive the written grievance, you may request an external review.

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 the Customer Service number on the back of your card or faxing BCNSC at 866-522-7345.

BCNSC will decide within 72 hours of receiving both your grievance and your physician's confirmation. If BCNSC tells you their decision verbally, BCNSC must also provide a written confirmation within two business days.

For a complete copy of the grievance policy, which includes more detail about your appeal rights and how soon BCNSC must respond go to bcbsm.com/resolve-problems or call Customer Service at 1-800-662-6667. TTY users can call 1-800-257-9980.

3.6 Additional Member Responsibilities

You have the responsibility to:

- Read the Member Handbook, this Benefit Document and all Group Health Plan documents.
- Call Customer Service at the number on the back of your BCNSC ID Card with any questions.
- Comply with the plans and instructions for care that you have agreed on with your practitioners.
- Provide, to the extent possible, complete and accurate information that BCNSC, BCN and Providers need in order to provide you with care.
- Make and keep appointments for non-emergent medical care. Notify the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Comply with the terms and conditions of the Coverage provided by Group Health Plan.

Section 4: Forms, Identification Cards, Records and Claims

4.1 Forms and Enrollment

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

You have the right to appeal our decision to Rescind your Coverage by following the Complaint and Grievance procedure described in this Benefit Document and in the Member Handbook. Or, you can call Customer Service at the number provided on the back of your BCNSC ID card.

4.2 Identification Card

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

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

If you have not received your card or your card is lost or stolen, please contact Customer Service immediately by calling the number listed in the Member Handbook. Information regarding how to obtain a new BCNSC ID card is also on our website at bcbsm.com.

4.3 Enrollment Records

- Enrollment records will be maintained by BCNSC as provided by MSU.
- Coverage will not be available unless information is submitted in a satisfactory format by MSU and/or Member.
- You are responsible for correcting any inaccurate information provided to MSU, BCNSC or BCN. If you intentionally fail to correct inaccurate information, you will be responsible to reimburse BCNSC for any service paid based on the incorrect information.

4.4 Authorization to Receive Information

By accepting Coverage described under this Benefit Document, you agree that:

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

4.5 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 reimbursed.

Section 5: Termination of Coverage

5.1 Termination of Group Coverage

Coverage described in this Benefit Document will continue in effect for the period of time the Administrative Services Contract (“ASC”) remains in effect. The ASC and Coverage continue from year to year, subject to the rights of Group, Group Health Plan and BCNSC to terminate

the ASC. Coverage for Members will terminate on the date the ASC is terminated as permitted by law.

5.2 Termination for Nonpayment

Nonpayment by Group

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

Nonpayment of Member Copayment, Coinsurance and Dependent Premium

BCNSC may terminate Coverage under the following conditions:

- If you fail to pay Copayments or other fees within 90 days of their due date;
- If you do not make or comply with acceptable payment arrangements with the Participating provider to correct the situation; or
- You fail to submit premium for Covered dependent within 31 days. NOTE: Any Covered Services incurred by the Covered dependent and paid by BCNSC after the date of last full payment will be charged, as permitted by law, to the individual Member.

The termination will be effective upon 60 days notice by BCNSC.

5.3 Termination of a Member's Coverage

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

- You no longer meet eligibility requirements.
- Coverage is cancelled for nonpayment.
- You misuse your Coverage
- Misuse includes illegal or improper use of your Coverage such as:
 - Allowing an ineligible person to use your Coverage
 - Requesting payment for services you did not receive
- You fail to repay BCNSC 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 BCNSC
- You are repaying BCNSC funds you received illegally
- You are serving a criminal sentence for defrauding BCNSC
- Your group changes to a non-BCN/BCNSC health plan
- We no longer offer this coverage
- BCN exits the small group market

- Your cessation of association membership

Rescission: If you commit fraud that in any way affects your Coverage or make an intentional misrepresentation of a material fact to obtain, maintain or that otherwise affects your Coverage, BCNSC will consider you in breach of contract and, upon 30 days written advance notice, your membership may be Rescinded. In some circumstances, fraud or intentional misrepresentation of a material fact may include:

- Misuse of the BCNSC ID card
- Intentional misuse of the BCNSC system
- Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCNSC complaint and grievance procedure. You can find this procedure in your Benefit Document, on our website at bcbsm.com or you can contact Customer Service at 1-800-662-6667 who will provide you with a copy.

5.4 Extension of Benefits

All rights to Benefits under Coverage end on the termination date except:

- Benefits will be extended for an authorized 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 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:

- The Member is discharged;
- You become eligible for other coverage; or
- The Benefits exhausted prior to the end of the contract.

Section 6: Conversion and Continuation Coverage

6.1 Loss Because of Eligibility Change

If you continue to be entitled to receive Benefits under the Group Health Plan, but no longer meet MSU coverage eligibility requirements, you must transfer to an alternate benefit program offered by MSU, if any. Contact MSU Human Resources at (800)353-4434 or (517)353-4434 for additional information regarding continuation of coverage.

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 Blue Care Network of Michigan, Inc. or Blue Cross Blue Shield of Michigan. Contact BCN Customer Service for information on non-group coverage.

6.2 COBRA Coverage

If you no longer meet the eligibility requirements as defined by MSU, 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 Administrator.

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 qualified beneficiaries the option of purchasing continuation coverage, you will need to be aware of the following conditions:

1. 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.
2. This coverage may continue for up to 18, 29 or 36 months depending on the reason for your initial ineligibility.
 - 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.
 - Continuation coverage and all Benefits cease automatically for a Group Member under **any** of the following:
 - The period allowed by law expires.
 - Your employer no longer includes BCNSC Coverage as a part of its Group Health Plan.
 - You begin coverage under any other benefit program or health coverage plan (with some exceptions).
 - You become eligible for Medicare.
 - You do not pay for Coverage fully and on time.

Section 7: General Provisions

7.1 Notice

Any notice that BCNSC 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 BCNSC.

7.2 Change of Address

You must update Membership records immediately when you change your address.

Please notify MSU and BCNSC. You must live in the Service Area at least six months out of each Plan year.

7.3 Heading

The titles and headings in this Benefit Document are not intended as the final description of your Coverage. They are intended to make your Benefit Document easier to read and understand.

7.4 Execution of Contract of Coverage

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

7.5 Assignment

The Coverage is for your personal benefit. Coverage cannot be transferred or assigned to another person.

If you try to assign Coverage to another person, all rights will be automatically terminated. BCNSC will pay providers only in accordance with provisions of this Benefit Document.

7.6 BCN Service Company (BCNSC)

BCNSC may adopt reasonable policies, procedures, rules and interpretations in order to administer this Benefit Document.

7.7 Litigation

- You may not bring any action or lawsuit under this Benefit Document unless you give BCNSC 30 days advance notice.
- You may not bring any action or lawsuit against BCNSC or BCN under this Benefit Document more than two years after a claim has arisen.
- Prior to bringing any action or lawsuit against BCNSC or BCN with respect to your Coverage, we encourage you to go through the Member grievance process.

7.8 Reliance on Verbal Communications 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, Medical Necessity verification, and the availability of Coverage at the time the claim is processed, as well as to the conditions, limitations, exclusions, maximums, Copayments, Coinsurance and/or Deductible under Coverage.

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

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

No agent or any other person except a senior executive officer of BCNSC has the authority to bind BCNSC by making promises or representations, or by giving or receiving any information.

7.9 Amendments

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

- Such changes must be made in accordance with the terms of the contract between MSU, Group Health Plan and BCNSC or by mutual agreement between the MSU, Group Health Plan and BCNSC.

7.10 Major Disasters

In the event of major disaster, epidemic or other circumstances beyond the control of BCNSC, BCNSC will attempt to perform Covered Health Services insofar as it is practical, according to BCNSC'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, BCNSC will be excused from performing services in support of Coverage so long as the circumstances continue.

Such circumstances include:

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

7.11 Obtaining Additional Information

The following information is available to you by calling BCN Customer Service at 1-800-662-6667 or by writing to BCN Customer Service at P.O. Box 5043, Southfield, MI 48086-5043.

- The current provider network in your Service Area
- The professional credentials of our 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
- The financial relationships between BCNSC and a Participating Provider
- Preauthorization requirements and any limitations, restrictions or exclusions on Services, Benefits or Providers

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

7.12 Right to Interpret Contract

During claims processing and internal grievances, BCNSC reserves the right to interpret and administer the terms of this Benefit Document and any Amendments to this Document. BCNSC's final adverse decisions regarding claims processing and grievances are subject to your right to appeal.

7.13 Out of Area Services

Services under this Benefit Document are covered only in the state of Michigan with the exception of emergency or BCNSC Preauthorized Services.

Covered Services received outside of Michigan will be administered through BlueCard, a Blue Cross Blue Shield Association program.

Definitions

BlueCard Participating Provider is a provider who participates with a Host Plan. (Defined below)

BlueCard Program is a program that allows BCNSC to process claims incurred in other states through the Host Plan, subject to Blue Cross and Blue Shield Association policies.

Designated Payment Level is the amount used to calculate your BCNSC Copayment/Coinsurance under the BlueCard Program as follows:

The amount is the lesser of:

- The provider's billed charges for Covered Health Services; or
- The amount based on other factors such as agreements with the Host Plan's provider community or historical average reimbursement levels.

NOTE: BlueCard Program policies permit Host Plans to adjust negotiated prices going forward to correct overestimation or underestimation of past prices. However, the Designated Payment Level used to calculate your Copayment and Coinsurance as stated in your Benefit Document or Amendments is considered final price.

Some state laws require that a special calculation be applied to determine the Host Plan's payment. In such instances, the Designated Payment Level will reflect any statutory requirements in effect at the time you receive care.

Host Plan is a Blue Cross Blue Shield Plan outside of Michigan that participates in the BlueCard Program and processes claims for services that you receive in that state.

How Services are Paid

If you receive Covered Health Services in another state from a BlueCard Participating Provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Coinsurance and Copayment required under your Benefit Document or Amendments. After the Host Plan pays the provider, BCNSC reimburses the Host Plan the amount required under the BlueCard Program as provided for in the Designated Payment Level, described above.

If the provider is not a BlueCard Participating Provider, we will pay for the Services as Out-of-Network (see Section 8) unless the Services are Emergency Services.

What You Must Pay

As a general rule, if your Covered Benefits include a Deductible you will be responsible for

payment of applicable Deductibles for Covered Health Services at the time those Services are received. If your Covered Benefits include a Copayment and Coinsurance, your Copayment/Coinsurance for Covered Services processed under the BlueCard Program will be calculated using the Designated Payment Level.

NOTE: Your Deductible, Coinsurance and Copayment requirements are based on your Benefit Document and Amendments and remain the same regardless of which Host Plan processes your claims for Services.

Exclusions and Limitations

BlueCard does not apply if:

- The Services are not a Benefit under this Benefit Document.
- The vendor or provider who provides the Services has a contract with BCNSC for those Services.

CHAPTER 2 - YOUR BENEFITS

Section 8: Your Benefits

Michigan State University Student Health Services (SHS) at Olin Health Center is the University's primary on-campus health facility for MSU students and their spouses/partners. Medical Services are provided by board-certified physicians and other certified medical professionals.

Except for treatment of an Emergency Medical condition, covered Members are required to utilize SHS at Olin Health Center before seeking off-campus treatment.

You may receive care at SHS Olin Health Center with some out-of-pocket costs. For general information, please call (517)884-OLIN (6546) or visit the website at <http://olin.msu.edu>.

Pediatric Members are not eligible to be seen at SHS at Olin Health Center but will be assigned a BCN Network pediatrician within a 45-mile radius of SHS at Olin Health Center. Out-of-Network providers may see Pediatric Members. Selecting a BCN Network Provider is recommended to minimize your Out-of-Pocket costs.

The Services listed in this chapter are covered when Services are provided in accordance with the Benefit Document requirements (including Referrals from SHS at Olin Health Center or other Participating Provider) and, when required, are Preauthorized or approved by BCN except in an Emergency.

IMPORTANT INFORMATION

- Medical Services provided in accordance with the terms of this Benefit Document are Covered Health Services only when they are Medically Necessary.
- Your health care Benefits are provided as a part of the Group Health Plan. BCNSC has contracted with MSU and Group Health Plan to administer your Coverage.
- As discussed in the introduction of this Benefit Document, BCNSC has arranged with BCN to provide administrative services to support your Coverage, including customer service and responsibility for Preauthorizations for Services.
- The Services listed in this chapter are covered when Services are provided in accordance with Coverage and, when required, are Preauthorized or approved by BCN.
- Coverage is subject to the limitations and exclusions listed in this Chapter.
- You are responsible for Deductible, Copayments and/or Coinsurance for many of the Benefits listed. If you receive a Service that we do not cover, you will be required to pay for that Service.
- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to a review of the diagnosis reported, verification of Medical Necessity, the availability of Benefits at the time the claim is processed, as well as the conditions, limitations,

exclusions, maximums, Coinsurance, Copayments and Deductible under your Benefit Document and Amendments.

- For a list of Services that require Preauthorization, contact Customer Service at the number provided on the back of your BCNSC ID card.
- Additional programs and Services, which include but are not limited to, disease management, prevention, wellness, and care management services defined in your Member Handbook, are Benefits available to Members.

You can find more details in the Member Handbook and on bcbsm.com.

8.1 Accessing Benefits

This Plan allows you to choose where to receive your health care. You may obtain Covered Health Services directly from SHS at Olin Health Center allowing you to receive Olin Health Center Benefits, or you can choose to receive Covered Health Care Services from a BCN Network Participating Provider or from Out-of-Network Non-Participating Provider.

Student Health Services at Olin Health Center - refers to Benefits for select Medical Services provided at (i) SHS at Olin Health Center; or (ii) referred by SHS at Olin Health Center and performed by a BCN Network Participating Provider. SHS at Olin Health Center is your designated Primary Care Provider.

You must use the resources of Olin Health Center first where treatment will be rendered or a Referral issued. A Referral is required if you receive services from BCN Network providers located within 45 miles of Olin Health Center.

Benefits will not be paid for care received within 45 miles of Olin Health Center without a Referral (except treatment of an emergency condition, maternity or mental health). Referrals must be renewed each Plan Year for continuing treatment to be covered. A separate Referral is required for each diagnosed condition.

Note to Dependent Children

Pediatric Members are not eligible to be seen at Olin Health Center. Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of Olin Health Center. However, Out-of-Network providers may see Pediatric Members. Referrals are not required for Services provided by BCN Network or Out-of-Network for all dependent children.

BCN Network Participating Providers – refers to Benefits for Services Referred by (i) SHS at Olin Health Center; or (ii) provided by a BCN Network Participating Provider. A Referral from Olin Health Center is not needed for Services provided by a BCN Network Participating Provider who is located outside of a 45-mile radius of Olin Health Center.

You are responsible for determining whether a provider is a BCN Network Participating Provider before obtaining Services. Unless otherwise specified in this Benefit Document, Benefits will be paid based on the status of the provider as of the day the Services are received.

Out-of-Network Benefits (Non-Participating) are generally paid at (i) a lower rate than Olin Health Center Benefits; or (ii) BCN Network Benefits; or (iii) may be excluded from Coverage. Out-of-Network Benefits are payable for Covered Health Services that are:

- Provided within the State of Michigan by a Non-Participating Physician, other Non-Participating provider or at a Non Participating Facility
- Provided outside of Michigan without utilizing the BlueCard Program

NOTE: You must notify BCNSC before receiving certain Covered Health Services from an Out-of-Network Provider. Notification requirements are detailed below with respect to applicable Benefits.

Preauthorization

Some Services provided in SHS at Olin Health Center, BCN Network and Out-of-Network require Preauthorization before they are covered. You are responsible for verifying Preauthorization for Services prior to obtaining the Service – except in an Emergency. Please refer to your BCNSC Member ID card for the appropriate telephone number to obtain Preauthorizations or if you have questions about Preauthorizations.

NOTE: Preauthorization is required for Inpatient, Outpatient Services or supplies.

Preauthorization is not a guarantee of payment.

8.2 Cost Sharing

Deductible

A Deductible is the amount you are responsible to pay before BCNSC will pay for Covered Health Services.

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

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

Per visit Copays or admission Copays do not apply towards satisfying the annual Deductible.

Your Deductible renews each Plan Year. It does not carry over into the new year.

Deductible		
SHS at Olin Health Center	BCN Network	Out-of-Network
This option waives the Deductible for Services received at Olin Health Center.	\$125 per Member per Plan Year \$250 per contract per Plan Year <ul style="list-style-type: none"> • Applies toward the Out-of-Pocket Maximum • Does not apply to Preventive Services 	\$250 per Member per Plan Year \$500 per contract per Plan Year <ul style="list-style-type: none"> • Applies toward the Out-of-Pocket Maximum • Does not apply to Preventive Services
If you use BCN Network and Out-of-Network Services, separate Deductible amounts apply. The Deductible for BCN Network and Out-of-Network is not combined to satisfy the Deductible limit.		

Copayment (Copay)

You are responsible for fixed dollar Copays for many of the Benefits listed in this Benefit Document. You are required to pay any Copays at the time you receive the Services. Copays count toward your Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, you will not be responsible for Copays for the remainder of the Plan Year.

Coinsurance

You are responsible for a percentage of the Approved Amount (Coinsurance) for many of the Benefits listed in this Benefit Document.

Your Coinsurance is dependent upon where you receive services from Olin Health Center, BCN Network, or Out-of-Network. Coinsurance amounts apply *after* you have met the Deductible.

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

Please refer to the specific section in this Benefit Document to determine your Coinsurance responsibility.

Cost Sharing – Deductible, Coinsurance and Copay Calculation

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

NOTE: Any Cost Sharing met in Olin Health Center, BCN Network or Out-of-Network is not combined.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you will pay for Covered Services under this Benefit Document and any applicable Amendments per Plan Year. The Out-of-Pocket Maximum includes your medical Deductible, Copay and Coinsurance.

Specific Services defined under this Benefit Document apply to the Out-of-Pocket Maximum.

Once you reach the Out-of-Pocket Maximum, you will not pay Deductible, Copayments or Coinsurance for Covered Services for the remainder of the Plan Year. The following exceptions do not apply to the Out-of-Pocket Maximum.

- Any Premium or contributions paid toward the Premium
- Balance Billing and charges paid by you in excess of the Approved Amount
- Health Care this Plan does not cover
- Non-Referred or non-Preauthorized Services

Your Out-of-Pocket Maximum renews each Plan Year. It does not carry over to the new year.

Out-of-Pocket Maximum		
SHS at Olin Health Center	BCN Network	Out-of-Network
\$1,500 per Member \$3,000 per contract per Plan Year		\$2,300 per Member \$4,600 per contract per Plan Year
If you use a BCN Network or Out-of-Network Services, separate Out-of-Pocket Maximum amounts apply. The Out-of-Pocket Maximum for BCN Network and Out-of-Network is not combined to satisfy the Out-of-Pocket Maximum.		

Note: The Out-of-Pocket Maximum as defined in this Benefit Document applies to medical Cost Sharing, which includes your pharmacy Cost Sharing.

Benefit Maximum

Some of the Covered Services described in the Benefit Document are covered for a limited number of days or visits per Plan 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 Plan Year even when continued care may be Medically Necessary.

Some examples of Covered Services that have a Benefit Maximum include but are not limited to the following.

- Outpatient physical, speech and occupational therapies
- Spinal manipulation

8.3 Professional (Physician) Services (Other Than Mental Health and Substance Use Disorder)

a) Office Visits - including specialist visits and outpatient office visits at a hospital site

Office Visit Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
<p>Olin Health Center is your assigned Primary Care Physician.</p> <p>Covered in full for first 3 visits of each school year for enrolled students only when provided at Olin Health Center</p> <p>\$15 Copay thereafter</p> <ul style="list-style-type: none"> ✓ Referral required from Olin for Services provided outside of Olin Health Center; within 45 miles radius 	<p>\$15 Copay after per visit</p> <ul style="list-style-type: none"> ✓ Referral required for services provided within 45 miles radius of Olin Health Center ✓ Referral is not required if BCN Participating physician is beyond 45-mile radius of Olin Health Center ✓ Preauthorization may be required ✓ Women's health does not require a Referral from Olin Health Center ✓ Deductible does not apply to Pediatric assigned PCP 	<p>Covered – 80% after Deductible</p> <p>20% Coinsurance of the Allowed Amount</p> <ul style="list-style-type: none"> • Responsible for Balance Billed charges • Referral is not required from Olin Health Center

b) Maternity Care - including prenatal and post-natal visits

Maternity Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
<p>Maternity Care Services are not provided at Olin Health Center - refer to BCN Network or Out-of-Network Benefits</p>	<p>Prenatal Services are covered in full.</p> <p>Postnatal Services - \$15 Copay after Deductible</p>	<p>Covered – 80% after Deductible</p> <p>20% Coinsurance of the Allowed Amount</p> <ul style="list-style-type: none"> • Responsible for Balance Billed charges
<p>A Referral is not required from Olin Health Center for maternity care, obstetric and gynecological treatment.</p>		

c) Home Visits - provided by a physician in the home or temporary residence. For additional information, refer to Home Health Care Services section.

Home Visits Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Home Visits are not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Unlimited visits		

d) Inpatient Professional Services - Physician Services provided while the Member is in an Inpatient hospital or Skilled Nursing Facility or Inpatient Rehabilitation center and billed by a physician

Inpatient Professional Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Inpatient Services are not provided by Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

e) Allergy Care - Allergy testing, evaluation, serum, and injection of allergy serum

Allergy Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Allergy testing and therapy are not provided at Olin Health Center. Allergy injections covered in full. Office visit Copay may apply.	Covered – 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

f) Chiropractic Services and Osteopathic Manipulative Therapy

when provided by a 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 Amendments for Cost Sharing information.

Benefit Maximum

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

Visits for mechanical traction are applied toward your Benefit Maximum for physical, speech and 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 Outpatient Therapy section.

Chiropractic Treatment Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Services are not provided at Olin Health Center - refer to BCN Network or Out-of-Network Benefits	Covered - \$15 Copay after Deductible then 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges
<p>Note: Benefits are limited to a maximum of 30 osteopathic and chiropractic visits per Member per plan year combined. Additionally, Olin Health Center, BCN Network and Out-of-Network visits are combined. For example, use of a visit in Olin Health Center will reduce the number of visits available in BCN Network and Out-of-Network.</p>		

8.4 Continuity of Care for Professional Services

Continuity of Care for Existing Members

When a contract terminates between BCNSC 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 BCNSC of his or her agreement to accept the Approved Amount as payment in full for the services provided;
- Continues to meet BCNSC's quality standards; and
- Agrees to adhere to BCNSC medical and quality management policies and procedures.

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

Medical Conditions and Coverage Time Limits

Pregnancy Related

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

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 BCNSC 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 and Acute medical conditions 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 BCNSC ended, whichever comes first. 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, BCNSC will continue to provide coverage at the BCN Network Benefit for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid at the BCN Network Benefit Level, your Participating Primary Care Physician must provide or coordinate all such services.

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

Continuity of Care for New Members

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

Coverage Time Limits and Qualification Criteria

Pregnancy Related

If you are in your second or third trimester of pregnancy at the time of enrollment, coverage provided by your Non-Participating Provider may continue through post-partum care for Covered Services directly related to your pregnancy.

Terminal Illness

If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the Non-Participating Provider related to your illness prior to enrollment, Coverage for services provided by your Non-Participating Provider may continue for the ongoing course of treatment through death.

Other Medical Conditions

For Chronic and Acute medical conditions when a course of treatment began prior to enrollment, Coverage for services provided by the Non-Participating Provider may continue through the current period of active treatment or 90 calendar days from the time of enrollment, whichever comes first.

Coverage

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

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

8.5 Preventive and Early Detection Services

We cover Preventive and Early Detection Services as defined in the federal PPACA. Preventive Services are modified by the federal government from time to time.

These Services must be provided or coordinated by your Primary Care Physician (SHS at Olin Health Center). Some Preventive Services are not performed at Olin Health Center but are provided in the BCN Network with no Cost Sharing. Cost Sharing does apply to Services received Out-of-Network.

Review the charts below before seeking Preventive Services.

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

Health screenings include but are not limited to:

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

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

b) Women's health and well-being

- Gynecological (well-woman) examinations including routine pap smear (lab service only)
- 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, administration; and management of side effects
- Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling*
- Routine prenatal office visits*

- Breast pump and associated supplies needed to support breast-feeding covered only when authorized and obtained from a participating Durable Medical Equipment provider and when mandated by law (Refer to DME 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*
- Female sterilization Services*
- Screening and counseling for interpersonal and domestic violence
- 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*

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% *Some Service may not be available at SHS at Olin Health Center. Check with Olin Health Center before receiving a Service. <ul style="list-style-type: none"> • A Referral is not required for mammograms. • You are encouraged to seek preventive Services in the BCN Network. 	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

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

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges
Flu shots are covered in full in Olin Health Center and BCN Network. Travel immunizations are not available at SHS at Olin Health Center.		

NOTE: Not all immunizations are mandated by PPACA. To see a list of the preventive immunizations that are covered by PPACA, go to www.uspreventiveservicestaskforce.org.

d) Newborn and well-child assessments and examinations

SHS at Olin Health Center	BCN Network	Out-of-Network
Pediatric Services are not available at SHS at Olin Health Center	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount • Responsible for Balance Billed charges

e) Nutritional counseling including Diabetes Self Management and diet behavioral counseling

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount • Responsible for Balance Billed charges

Other nutritional counseling Services may be covered when Preauthorized by BCN.

NOTE: Certain health education and health counseling Services may be arranged through your Participating Provider, but are not payable under your Coverage. Examples include but are not limited to:

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

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

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% <ul style="list-style-type: none"> Some Service may not be available at Olin Health Center. Check with Olin Health Center for specific Service. You are encouraged to seek Preventive Services in the BCN Network 	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

g) Depression Substance Use Disorder/chemical dependency screening

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

h) Aspirin therapy counseling for the prevention of cardiovascular disease

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

i) Tobacco use and tobacco caused disease counseling

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

		<ul style="list-style-type: none"> Responsible for Balance Billed charges
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NOTE: If this Benefit Document is amended by Deductible, Copayment and/or Coinsurance (“Cost Sharing”) Amendments, the attached Amendments will take precedence over the Benefit Document for non-preventive services.

Cost Sharing will apply to non-routine diagnostic procedures. Any Member Cost Sharing for office visits will still apply with the following restrictions:

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

Note: To see a list of the Preventive Benefits and immunizations that are mandated by PPACA, go to www.uspreventiveservicestaskforce.org. You may also contact BCN Customer Service.

8.6 Inpatient Hospital Services

The following Inpatient Hospital (Facility) Services are covered when they are Medically Necessary and Preauthorized by BCN. Benefits for Physician Services are described under Professional Physician Services section.

- Room and board, general nursing Services and special diets
- Operating and other surgical treatment rooms, delivery room and special care units
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, inhalation therapy and dialysis
- Physical, speech and occupational therapy
- Long term Acute Care
- Other Inpatient Services and supplies necessary for the treatment of the Member
- Maternity care and all related services

NOTE: 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.

- Newborn care

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

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

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

The baby must be eligible for coverage and must be added to your contract within the time stated in Section 1.

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Inpatient Hospital Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered – 95% after Deductible 5% Coinsurance • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the allowed amount • Preauthorization required • Responsible for Balance Billed charges

8.7 Outpatient Services

Outpatient Services are covered when they are Medically Necessary and Preauthorized by BCN. Outpatient Services include Services and other procedures when performed in an office setting, Outpatient hospital setting, specialty clinic or freestanding ambulatory center for dialysis or treatment of a disease, injury or other medical condition. Outpatient Services include but are not limited to:

- Surgery
- Anesthesia
- Laboratory and pathology Services
- Radiology
- Injections (except as excluded in Section 9)

- Chemotherapy, inhalation therapy and radiation therapy
 - Dialysis
 - Diagnostic tests
 - Physical, speech and occupational therapy – See Outpatient Therapy Services section
 - Durable Medical Equipment – see Durable Medical Equipment section
 - Diabetic Supplies and Equipment – see Diabetic Supplies and Equipment section
 - Prosthetic and orthotic equipment and supplies – see Prosthetics and Orthotics section
- Other Medically Necessary Outpatient Services and supplies

Outpatient Services Cost Sharing Facility and Professional Services		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% <ul style="list-style-type: none"> • Some Services are not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits 	Covered - 95% after Deductible 5% Coinsurance <ul style="list-style-type: none"> • Preauthorization required 	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

Note: Outpatient diagnostic laboratory and pathology tests are covered in full.

High Technology Outpatient Services Cost Sharing Such as CAT, MRI and PET scans Facility and Professional Services		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance <ul style="list-style-type: none"> • Preauthorization required 	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

8.8 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. Broken bones and cuts, allergic reactions, frostbite, sunstroke, swallowing poison, overdose of medication and inhalation of smoke, carbon monoxide or fumes are considered accidental injuries.
- **Emergency Services** - Services to treat Medical Emergency conditions as described below.
- **Medical Emergency** - the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Routine care for minor medical problems such as headaches, colds, slight fever, back pain or follow-up care is not considered a medical emergency. A “Medical Emergency” is not a condition caused by an “accidental injury”.
- **Stabilization** - the point at which there is reasonable probability 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 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 are covered up to the point of Stabilization when they are Medically Necessary and needed either 1) for immediate treatment of a condition that is a Medical Emergency as described above or 2) if the Primary Care Physician directs you to go to an emergency care Facility.

In case of such a Medical Emergency or Accidental Injury, you should seek treatment at once. We urge you, the hospital or someone acting for you, to notify your Primary Care Physician or BCN within 24 hours, or as soon as medically reasonable.

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

Emergency Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - \$50 Copay then 5% Coinsurance thereafter	Covered - \$50 Copay then 5% Coinsurance thereafter

Urgent Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance

NOTE: The Emergency Copayment may be waived for a Medical Emergency or Accidental Injury based upon presenting signs and symptoms as defined by BCNSC.

If you are admitted as an Inpatient because of a Medical Emergency or Accidental Injury, the Emergency Copay is waived. Instead, you will be responsible for the Inpatient Hospital Benefit as defined in Section 8.6.

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

Follow-up care in an Emergency Care Center or Urgent Care Center, such as removal of stitches and dressings, is covered. If within 45 miles of Olin Health Center, you must return to Olin Health Center for follow-up care, even if the Emergency Room Physician refers you to someone else.

Emergency Services at a Non-Participating Hospital

If you are hospitalized in a Non-Participating Facility, we may require that you be transferred to an affiliated Hospital as soon as you are Stabilized. If you refuse to be transferred, the hospitalization and related Covered Health Services will be covered as an Out-of-Network Benefit from the date of Stabilization.

Out-of Area Coverage

You are covered when traveling outside of the BCN Service Area for Emergency Services and Urgent Care Services that meet the conditions described above. (See Section 7.13 for additional information regarding out-of-area Coverage.)

8.9 Ambulance

An ambulance is a vehicle specially equipped and licensed for transporting injured or sick persons.

The following ambulance Services are covered.

Air ambulance When transport is ordered by the attending physician and the following conditions are met:

- The use of an air ambulance is medically necessary.

- No other means of transport is available, or the Member's condition requires transport by air 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. The facility must be:
 - The nearest facility, or
 - Another appropriate facility within a reasonable distance of the nearest available facility
 - BCN will determine whether a facility is appropriate and what a reasonable distance is.

Emergency ground ambulance services when:

- You are admitted as an Inpatient to the Hospital immediately following emergency room treatment;
- The Services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management;
- The Services are needed for emergency delivery and care of a newborn and mother, but not for normal or false labor; or
- The ambulance is ordered by an employer, school, fire or public safety official, and you are not in a position to refuse.

Non-Emergency ground ambulance services are covered only when those Services are recommended by your treating physician and Preauthorized by BCN.

Ambulance Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - 95% 5% Coinsurance	Covered - 95% 5% Coinsurance

Exclusions include but are not limited to

- Transportation and/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.
- Ambulance Services provided by an Emergency responder that does not provide on-site treatment and transportation are not covered. The on-site treatment is covered regardless

if transportation is provided.

- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.

8.10 Reproductive Care and Family Planning Services

This Benefit includes:

- Infertility
- Sterilization
- Termination of Pregnancy
- Genetic Testing

a) Infertility

Basic Infertility

Coverage includes diagnosis, counseling, select drugs and surgical treatment of Infertility when Medically Necessary and Preauthorized by BCN except as stated below and in Section 9. Following the initial sequence of diagnostic work-up, additional work-ups may begin only when BCN determines they are in accordance with generally accepted medical practice.

Comprehensive Infertility

- Ovulation induction with menotropins is subject to the Benefit Maximum of 6 cycles per lifetime.
- Intrauterine insemination is subject to the maximum Benefit of 6 cycles per lifetime.

Infertility Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefit	Covered - 95% after Deductible 5% Coinsurance • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount • Responsible for Balance Billed charges
<p>Note: Infertility Services are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.</p>		

Exclusions include but are not limited to

- Harvesting
- Storage or manipulation of eggs and sperm

- Services for the partner in a couple who is not enrolled with BCNSC and does not have coverage for infertility Services or has other Coverage
- In-vitro fertilization 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

b) Sterilization

Coverage includes Inpatient; Outpatient and office based adult sterilization Services.

Female sterilization - Covered in full as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services.

Female Sterilization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered – 100%	Covered - 80% after Deductible; 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

Male Sterilization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

Exclusion includes but is not limited to

Reversal of surgical sterilization for males and females

c) Termination of Pregnancy

First trimester elective termination of pregnancy (up to the end of the 13th week of pregnancy) is covered – one procedure in each two-year period of membership.

Termination of Pregnancy Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Note: Benefit is limited to \$250 per Plan Year.		

d) Genetic Testing

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

Genetic Testing Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

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)

Exclusion includes but is not limited to

Genetic testing and counseling for non-members

8.11 Skilled Nursing Facility Services

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

Skilled Nursing Facility Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Unlimited days		

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)

8.12 Home Health Care Services

Home Health Care Services are provided by health care professionals who are employed by the home health care agency or by providers who participate with the agency. Home Care Services include:

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy
- Hospice Care
- Other health care Services approved by BCN when they are performed in the Member’s home

Home Care Services are covered when they are Medically Necessary.

Home Health Care Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Unlimited visits		

Exclusions include but are not limited to

- Housekeeping services
- Custodial Care (See Section 9)

8.13 Hospice Care

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

Hospice Care received from a licensed hospice agency, in the home, in a Skilled Nursing Facility or in a licensed hospice Facility is covered for the following services when Medically Necessary and Preauthorized by BCN.

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

Hospice Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

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 receiving Custodial Care

8.14 Home Infusion Therapy Services

Home infusion therapy Services provide 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 Home).

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.

Home infusion therapy Services are covered when Medically Necessary and Preauthorized by BCN.

Home Infusion Therapy Services Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount • Responsible for Balance Billed charges

8.15 Mental Health Care

Evaluation, consultation and treatment necessary to determine a diagnosis and Treatment Plan for mental health conditions are covered when Preauthorized by BCN as Medically Necessary. (Mental Health Emergency Services are covered pursuant to Emergency and Urgent Care section.)

- Coverage is limited to solution-focused treatment and crisis interventions. Solution-focused treatment includes both individual and group sessions.
- Coverage is limited to treatments that are expected to result in measurable, substantial and functional improvement.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic illness or to those Outpatient services that are Medically Necessary in order to prevent an Acute episode of a Chronic illness.
- A separate Preauthorization by BCN is required for Medical Services needed during a period of mental health admission.

Definitions

- **Assertive Community Treatment** is a Service-delivery model that provides intensive, locally based treatment to people with serious and persistent mental illness.
- **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.
- **Intensive Outpatient Mental Health** services are Acute Care Services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 2 days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.
- **Outpatient Mental Health Services** include individual, conjoint, family or group psychotherapy and crisis intervention.
- **Partial Hospitalization Mental Health** is a comprehensive, Acute Care program that consists of a minimum of 6 hours per day, 5 days a week. Treatment may include, but is not limited to counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan. Partial Hospitalization Services are often provided in lieu of Inpatient psychiatric Hospitalization.
- **Residential Mental Health Treatment** is treatment that takes place in a licensed mental health Facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 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; and
 - 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.

Coverage

Mental Health Care is covered in either an Inpatient or Outpatient setting.

To obtain Services call BCN Behavioral Health Management at the number shown on the back of your BCNSC ID Card. They are available 24 hours a day, 7 days a week. You do not need a Referral to get care.

Inpatient Mental Health/Residential Mental Health/Partial Hospitalization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Not applicable	Service must be Preauthorized by BCN Behavioral Health Management.	

Outpatient Mental Health/Intensive Outpatient Mental Health Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
3 visits per lifetime are covered in full for enrolled students only when provided at Olin Health Center Covered – \$15 Copay thereafter	Covered – \$15 Copay after Deductible, no matter the location	Covered – \$15 Copay after Deductible
Service must be Preauthorized by BCN Behavioral Health Management.		

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.

8.16 Substance Use Disorder/Chemical Dependency Services

Substance Use Disorder/Chemical Dependency treatment means treatment for physiological or psychological dependence on or abuse of alcohol, drugs or other substances. This treatment may include drug therapy, counseling, Detoxification Services, medical testing, diagnostic evaluation, and Referral to other Services in a treatment plan.

All Substance Use Disorder/Chemical Dependency treatments must be Preauthorized as Medically Necessary except in an emergency. (See Section 8.8)

- Coverage is limited to solution focused treatment and crisis intervention. Solution focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are covered.

- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic Illness or to those Outpatient Services that are Medically Necessary in order to prevent an Acute episode of a Chronic Illness.
- Medical Inpatient Services required during a period of Substance Use Disorder admission must be Preauthorized separately by 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, Outpatient or Residential setting.
- **Domiciliary Partial** refers to Partial Hospitalization combined with an unsupervised Residential (overnight) component.
- **Intensive Outpatient Substance Use Disorder Treatment** means day treatment that is provided on an Outpatient basis. Intensive Outpatient Substance Treatment consists of a minimum of 3 hours per day, 2 days per week and may include, but is not necessarily limited to, individual, group and family counseling, medical testing, diagnostic evaluation and/or Referral to other Services in a treatment plan.
- **Intermediate Care** refers to Substance Use Disorder Services that have a Residential (overnight) component. Intermediate Care includes Detox, domiciliary Partial and Residential (including Inpatient and Rehabilitation) Services.
- **Outpatient Substance Use Disorder Treatment** means Outpatient visits (e.g., individual, conjoint, family or group therapy) for a Member who is dependent on and/or abusing alcohol or drugs or both. The visit may include counseling, Detox, medical testing, diagnostic evaluation and Referral for other Services.
- **Partial Hospitalization/Domiciliary Partial** is a comprehensive, Acute Care program that consists of a minimum of 6 hours per day, 5 days a week. Partial Hospitalization treatment may include, but is not necessarily limited to, counseling, medical testing, diagnostic evaluation and/or Referral to other Services in a treatment plan.
- **Residential Substance Use Disorder Treatment** means Acute Care Services provided in a structured and secure (24 hour) per day setting to a Member who is ambulatory and does not require medical hospitalization. Residential Substance Use Disorder Treatment may include 24-hour professional supervision and may include counseling, Detox, medical testing, diagnostic evaluation and Referral or other Services specified in a treatment plan. Residential Substance Use Disorder treatment is sometimes referred to as Inpatient Substance Use Disorder treatment or Rehabilitation.

Coverage

Substance Use Disorder Services including counseling, medical testing, diagnostic evaluation and Detox are covered in a variety of settings.

To obtain Services you can call BCN Behavioral Health Management available 24 hours a day, 7

days a week at the number provided on the back of your BCNSC ID card. You do not need a Referral to get care.

Detoxification/Residential/Intermediate Care/Partial Hospitalization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
Not applicable	Service must be Preauthorized by BCN Behavioral Health Management.	

Outpatient/Intensive Outpatient Substance Use Disorder Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – \$15 Copay	Covered – \$15 Copay after Deductible, no matter the location	Covered – \$15 Copay after Deductible
Service must be Preauthorized by BCN Behavioral Health Management.		

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.

8.17 Outpatient Therapy Services

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

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

We cover Short-term Outpatient Therapy Services when

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

Habilitative Services that help a person keep, learn or improve skills and functioning for daily living are covered when Preauthorized by BCN as Medically Necessary. Examples include but are not limited to:

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

Short term Rehabilitative Outpatient Physical, Speech, Cognitive and Occupational Therapies Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered - \$15 Copay per visit <ul style="list-style-type: none"> • Physical therapy only is available at Olin Health Center • Speech therapy and occupational therapy are available in BCN Network and Out-of-Network 	Covered – \$15 Copay after Deductible; 5% Coinsurance thereafter	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges
✓ Outpatient Cognitive, Physical and Occupational Therapy - Limited to a combined Benefit Maximum of 30 visits per condition per Plan Year with Habilitative PT/OT visits ✓ Outpatient Speech Therapy – limited to 30 visits per Plan Year combined with Habilitative Speech therapy visits		

Habilitative Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered - \$15 Copay per visit Physical therapy only is	Covered – \$15 Copay after Deductible; 5% Coinsurance thereafter	Covered - 80% after Deductible 20% Coinsurance of the

available at Olin Health Center Speech therapy and occupational therapy are available in BCN Network and Out-of-Network		Allowed Amount • Responsible for Balance Billed charges
<ul style="list-style-type: none"> ✓ Outpatient Physical and Occupational Therapy – limited to a combined Benefit Maximum of 30 visits per condition per Plan Year combined with Rehabilitative visits ✓ Outpatient Speech Therapy – limited to 30 visits per Plan Year combined with Rehabilitative speech therapy visits 		

NOTE: The maximum number of Outpatient therapy visits received is combined. For example, use of a visit in the BCN Network will reduce the visits available Out-of-Network.

General exclusions include but are not limited to

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

Speech therapy exclusions include but are not limited to

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

8.18 Durable Medical Equipment (DME)

Durable Medical Equipment (DME) must be:

- Medically Necessary
- Preauthorized by BCN
- Used primarily for medical purposes
- Prescribed by Olin Health Center or your treating physician
- Intended for repeated use
- Be useful primarily because of illness, injury or congenital defect.

Coverage

We cover rental or purchase of DME when limited to the basic equipment. Any supplies required to operate the equipment and special features must be considered Medically Necessary and Preauthorized by BCN.

DME is not available Out-of-Network. Items must be obtained from a BCN DME Participating Provider.

In many instances, BCNSC 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.

Durable Medical Equipment Cost Sharing Must be Preauthorized and obtained from a BCN Participating Provider
Covered – 95% after Deductible; 5% Coinsurance Applies to Out-of -Pocket Maximum
For specific Coverage information and to locate a BCN Participating Provider, please call the number provided on the back of your BCN ID card. NOTE: Limited DME supplies are available at SHS at Olin Health Center when Preauthorized.

NOTE: Breast pump needed to support breast-feeding as required by law is covered in full 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
- Medically Necessary
- Preauthorized by BCN
- Appropriate for use in the home
- Obtained from a BCN Network Participating Provider (Limited supplies are available at SHS at Olin Health Center)
- Prescribed by Olin Health Center or a treating physician

- 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 only when needed as determined by BCN resulting from body growth, body change or normal use
- Repair of the item if it does not exceed the cost of replacement

Exclusions include but are not limited to

- Deluxe equipment (such as motor-driven wheelchairs and beds, etc.) unless Medically Necessary for the Member and/or required so the Member can operate the equipment. (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 Member's option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that may be prescribed.)
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bed boards, bathtub lifts, overhead tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds)
- Physician's equipment (such as 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

8.19 Diabetic Supplies and Equipment

Diabetic supplies and equipment are used for the prevention and treatment of clinical diabetes.

Diabetic supplies must be -

- Medically Necessary

- Preauthorized by BCN
- Prescribed by your Olin Health Center or treating physician
- Obtained from a BCN Participating Provider

We cover -

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

Diabetic supplies and equipment are limited to basic equipment. Special features must be Medically Necessary and 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 is covered if it does not exceed the cost of replacement.

Diabetic Supplies and Equipment Cost Sharing Must be Preauthorized and obtained from a BCN Participating Provider
Covered – 95% after Deductible; 5% Coinsurance Applies to Out-of-Pocket Maximum
For specific Coverage information and to locate a BCN Participating provider, please call the number provided on the back of your BCN ID card. NOTE: Limited supplies are available at SHS at Olin Health Center when Preauthorized.

Exclusions include but are not limited to

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

8.20 Orthotics and Prosthetics

Definitions

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

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

Prosthetic Devices can be either:

External: Devices such as an artificial leg, artificial arm or the initial set of prescription lenses for replacement of an organic lens of the eye following Medically Necessary eye surgery (e.g. cataract surgery) are considered external devices.

Internal Implantable Prosthetic Devices: Devices surgically attached or implanted during a Preauthorized surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, implanted lens immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g. cataract surgery) are considered internal devices.

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

Coverage

We cover the following -

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

Orthotics and Prosthetics Cost Sharing Must be Preauthorized and obtained from a BCN Participating Provider
Covered – 95% after Deductible; 5% Coinsurance Applies to Out-of-Pocket Maximum
For specific Coverage information and to locate a BCN Participating provider, please call the number provided on the back of your BCN ID card. Limited devices are available at SHS at Olin Health Center when Preauthorized.
NOTE: Hair prosthesis (wig or hairpiece) for hair loss due to injury, sickness or the treatment of sickness are covered in full.

Internal Implantable Prosthetic Devices

Your Inpatient, Outpatient or office visit Benefit applies.
Applies to the Out-of-Pocket Maximum

Limitations and exclusions

Limitations include but are not limited to

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

Exclusions include but are not limited to

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

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

8.21 Organ and Tissue Transplants

We cover organ or body tissue transplant and all related Services when the following conditions are met.

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

Donor Coverage for a BCNSC 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-BCNSC Recipient

Member donor Cost Sharing may apply (as defined in this Benefit Document) when Preauthorized if the recipient’s health plan does not cover BCNSC Member donor charges.

Organ and Tissue Transplant Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not available at Olin Health Center	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

Exclusions include but are not limited to

- Community wide searches for a donor

8.22 Reconstructive Surgery

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

- Correction of a birth defect that affects function;
- Breast reconstructive surgery following a Medically Necessary mastectomy. 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
- Reduction mammoplasty (breast reduction surgery) for females
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Health Service under this Benefit Document, disease, accidental injury, burns and/or severe inflammation
- Male mastectomy for treatment of gynecomastia

Reconstructive surgery is covered only when it is Medically Necessary and Preauthorized by BCN.

Reconstructive Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges

8.23 Oral Surgery

Oral surgery and X-rays are covered only when Medically Necessary and Preauthorized by BCN.

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw;
- Dental anesthesia for oral surgery in an outpatient setting when Medically Necessary and Preauthorized by BCN;
- Medically Necessary surgery for removing tumors and cysts within the mouth;

NOTE: 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. Your Inpatient Hospital benefit will apply.

- Immediate repair of trauma to natural teeth which includes the evaluation and treatment performed on the injured teeth within 72 hours from the traumatic occurrence.

NOTE: Any follow-up treatment performed after the first 72 hours post-injury is not covered.

Oral Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> Responsible for Balance Billed charges
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

Exclusions include but are not limited to

- Anesthesia administered in an office setting
- Rebuilding or repair for cosmetic purposes
- Orthodontic treatment even when provided along with oral surgery

- Surgical preparation for dentures
- Routine dental procedures
- Surgical placement of dental implants including any procedure in preparation for the dental implant such as bone grafts

See Section 9 for additional exclusions.

8.24 Temporomandibular Joint Syndrome (TMJ) Treatment

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

Coverage

We cover medical services and treatment for TMJ when Medically Necessary and Preauthorized by BCN.

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

TMJ Treatment Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

Exclusions include but are not limited to

- Dental and orthodontic Services, treatment, prostheses and appliances for or related to TMJ treatment (Occlusal splints limited to one per lifetime - covered only when diagnosed with TMJ and medically necessary)
- Dental X-rays

8.25 Orthognathic Surgery

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

The Services listed below are covered when they are Medically Necessary and Preauthorized by BCN.

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

Orthognathic Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

Exclusion includes but is not limited to

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

8.26 Weight Reduction Procedures

Weight reduction procedures for the surgical treatment of morbid obesity are covered when:

- The medical criteria and guidelines established by BCN for having the procedure are met.
- The procedure is Preauthorized by BCN as Medically Necessary.

Weight Reduction Procedures Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance

		Billed charges
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

Benefit Maximum

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

8.27 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 questions is Medically Necessary for the Member, based on BCN's approved criteria. Those Covered drugs are not payable without Prior Authorization by BCN.

a) Prescription Drugs Received while you are an Inpatient

We cover prescription drugs and supplies that are prescribed and received during a covered Inpatient Hospital stay as medical Benefits.

b) Cancer Drug Therapy

We cover cancer drug therapy and the cost of administration. The U. S. Food and Drug Administration (“FDA”) must approve the drug 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		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered in full	Covered in full

Cost of Administration

SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered in full	Covered in full

Coordination of Benefits for cancer therapy drugs

If you have BCNSC Prescription Drug Amendment, drugs for cancer therapy that are self-administered will be covered by your BCNSC Prescription Drug Amendment before Coverage under this Benefit Document will apply.

c) Injectable Drugs

The following drugs are covered as medical Benefits.

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

We may require selected Specialty Drugs be obtained by your Provider through a Specialty Pharmacy. BCNSC 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 have a BCNSC Prescription Drug Amendment attached to this Benefit Document.

Exclusions include but are not limited to

Drugs that are intended to be self-administered as defined by the FDA not covered under your medical Benefit. This includes self-administered drugs for certain diseases, such as arthritis, hepatitis, multiple sclerosis, and other illnesses or injuries. Self-administered drugs are covered only when you have a BCNSC Prescription Drug Amendment.

d) Outpatient Prescription Drugs

We do not cover Outpatient Prescription Drugs and supplies unless you have a BCNSC Prescription Drug Amendment attached to this Benefit Document. (See Section 9).

8.28 Clinical Trial

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 PPACA;
- 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 PPACA.

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 Benefit Document 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 he/she meets the trial's protocol.

Routine Patient Costs means all items and Services related to an approved clinical trial if they

are covered under this Benefit Document or any attached Amendments 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).
- The treatment is covered under your Benefit Document and attached Amendments when it is provided as conventional treatment.
- The Services related to the Experimental treatment are covered under this Benefit Document and attached Amendments 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 Benefit Document 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 Benefit Document.
- 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.

8.29 Autism Spectrum Disorders

Definitions

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

Approved Autism Evaluation Center ("AAEC") is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the ASD. AAEC evaluation is necessary for ABA.

Autism Spectrum Disorders ("ASD") is 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, 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 the person diagnosed with ASD according to the 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 Benefit Document.

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 physician or a Participating psychologist and include assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule. Services for the treatment of ASD are covered as follows:

- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's ASD
- 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, Participating speech therapist and physical therapist)
 - ABA (when performed by a Participating BCBA and Participating psychologist)
 - Outpatient mental health therapy (when performed by a Participating social worker, clinical psychologist and psychiatrist)
 - 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 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 19. 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 subject to the Cost Sharing as defined below. You are required to pay any Copayment at the time the Service is rendered. You are responsible for meeting the Deductible prior to BCNSC paying for Covered Services.

Behavioral Health Services included in the Treatment Plan are subject to the BCN Network office visit Copay or Out-of-Network Cost Sharing as defined in Section 8.15 of this Benefit Document. You are responsible for meeting the Deductible prior to BCNSC paying for Covered Services.

Outpatient Therapy Services included in the Treatment Plan are subject to the Cost Sharing as defined in Section 8.17 Outpatient Therapy Services. You are required to pay any Copay at the time of service. You are responsible for meeting the Deductible prior to BCNSC paying for Covered Services.

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

This Coverage overrides certain exclusions as defined in this Benefit Document such as:

- Exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities;

- Treatment solely to improve cognition concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control; and
- Other behaviors for which behavior modification is sought.

Applied Behavioral Analysis Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - \$15 Copay after Deductible	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount <ul style="list-style-type: none"> • Responsible for Balance Billed charges

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 Applied Behavior Analysis** - The Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, development pediatrician or other professional as agreed upon by the AAEC in order to receive Preauthorization for ABA. Other Preauthorization requirements may also apply. The requirement to be evaluated and diagnosed by the 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 terminate on the child’s 19th birthday
- **Treatment Plan** - Services must be included in a Treatment Plan recommended by an 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

- 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

8.30 Gender Dysphoria Treatment

Definition

Gender Dysphoria

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

Gender Reassignment Services

A collection of Services that are used to treat Gender Dysphoria. These services must be considered Medically Necessary and may include hormone treatment and/or 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.

Gender Dysphoria Treatment Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Some services are available at Olin. Cost Share applied dependent on the service provided.	Covered - 90% after Deductible 10% Coinsurance	Covered – 70% after Deductible 30% Coinsurance of the Allowed Amount Responsible for Balance Billed charges
Your Inpatient and Outpatient Benefit Cost Sharing applies including office consultations as defined in this Benefit Document.		

Exclusions include but are not limited to

- Experimental or investigational treatment
- Reversal of transgender surgical procedures
- Gender reassignment services that are considered cosmetic and not medically necessary such as:
 - Abdominoplasty
 - Blepharoplasty
 - Breast enhancements
 - Brow lift
 - Calf implants
 - Cheek/malar implants
 - Chin/nose implants
 - Chondrolaryngoplasty (Adams Apple reduction)
 - Collagen injections
 - Construction of clitoral hood

- Drugs for hair loss or growth
- Forehead lift
- Hair removal
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Speech-language therapy
- Non-covered services

Note: Coverage is subject to change based on annual medical policy review.

Section 9: Exclusions and Limitations

This section lists the exclusions and limitations of this Benefit Document. Please refer to a specific Service within this Benefit Document for additional exclusions and limitations.

9.1 *Unauthorized Services*

Select health, medical and Hospital Services listed in this Benefit Document are covered **only** if they are Preauthorized by BCN.

Current information regarding Services that require Preauthorization is available by calling Customer Service at the number shown on the back of your BCNSC ID card.

9.2 *Services Received While a Member*

A Service is considered to be received on the date you have the Service or get a supply. Only the Covered Services you receive while you are a Member, covered under this Benefit Document and attached Amendments will be paid.

You are responsible for all costs for Covered Services that you receive after your Coverage terminates, plus the cost of recovering those charges (including attorney's fees).

9.3 *Services That Are Not Medically Necessary*

Services that are not Medically Necessary are not covered unless specified in this Benefit Document.

The Medical Director makes the final determination of Medical Necessity based upon BCN internal medical policies.

9.4 *Non-Covered Services*

Coverage does not include the following Services:

- Services that do not meet the terms and guidelines of this Benefit Document
- Office visits, exams, treatments, tests and reports for any of the following:
 - Employment
 - Licenses
 - Insurance
 - Travel (immunizations for purposes of travel or immigration are a Covered Health Benefits)
 - School purposes, camp registration, and sports physicals
 - Educational and behavioral evaluations performed at school
 - Legal proceedings such as parole, court and paternity requirements
 - Completion or copying of forms or medical records, medical photography, charges and interest on late payments, and charges for failure to keep scheduled appointments
- Cognitive services including but not limited to those pertaining to perception, attention, memory or judgment. Examples include cognitive training, retraining and rehabilitation;

skills and memory therapies; stress reduction; relaxation therapies and biofeedback.

- Food and dietary supplements, vitamins, minerals, and infant formula. (This exclusion does not apply to enteral feedings when they are your or a dependent's sole source of nutrition)
- Expenses of travel and transportation and/or lodging, except for covered ambulance services
- Autopsies
- Employment related counseling
- Modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities
- Fees incurred for collections, processing and storage of blood, cells, tissues, organs or other bodily parts in a family, private or public cord bank or other facility without immediate medical indication
- Testing to determine parentage or DNA testing
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself
- Services performed by a provider with your same legal residence
- Charges in excess of the Approved Amount
- Private duty nursing
- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
- Services outside the scope of the practice of the servicing provider
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

9.5 Cosmetic Treatment and Procedures

Cosmetic treatment and procedures are performed primarily to improve appearance and/or self-esteem. It does not correct or materially improve a physiological function.

We do not cover cosmetic surgery including, but not limited to:

- Elective rhinoplasty
- Spider vein repair
- Breast augmentation
- Treatment of acne
- Any related Services, such as pre-or post-surgical care, follow-up care or reversal or

revision of the surgery

9.6 Prescription Drugs

There is no Coverage 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, a prescription drug Amendment may be issued to you that allows Coverage.

9.7 Military Care

Care for diseases or disabilities connected with military service are not covered if you are legally entitled to obtain services from a military Facility, and such a Facility is available within a reasonable distance.

9.8 Custodial Care

Custodial Care is used to maintain the basic need for food, shelter, housekeeping Services and clothing. Custodial Care is not a covered benefit.

Custodial Care is not covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and Skilled Nursing Care.

9.9 Comfort and Convenience Items

Coverage does not include the following even when the items are prescribed by a Physician.

- Personal comfort
- Convenience items
- Telephone
- Television or similar items
(See also Durable Medical Equipment section for exclusions)

9.10 Mental Health/Substance Use Disorder

Coverage does not include the following Services:

- Care provided by Non-Participating facilities except for emergency admissions to the point of stabilization
- Psychoanalysis and open-ended psychotherapy
- Custodial (non-skilled) Care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living (ADL) or to keep from continuing unhealthy activities
- 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

- Maintenance treatments for caffeine and opiate addiction
- Treatment of Chronic illnesses is limited to:
 - Treatment that is Medically Necessary to prevent an Acute episode of Chronic illness
 - Treatment of Acute exacerbation of Chronic illness (any level of care, subject to other exclusions).
- 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
- Marital counseling Services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider
- Gambling addiction issues
- Care, Services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes are not covered as separate charges

9.11 Court Related Services

- There is no coverage for court ordered services including but not limited to pretrial and court testimony, a court-ordered exam or the preparation of court-related reports that do not meet Coverage requirements.
- There is no coverage for court-ordered treatment for Substance Use Disorder or mental illness except as specified in Sections 8.
- There is no coverage for services related to your commission of a crime or participation in an illegal activity.
- There is no coverage for services rendered while you are in the custody of law enforcement.

9.12 Elective Procedures

The following Elective Procedures are not covered.

- Reversal of surgical sterilization

- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer and all related Services
- Artificial insemination except for the diagnosis of infertility as described in this document
- All Services related to surrogate parenting arrangements, including, but not limited to, maternity and obstetrical care for non-member surrogate parents
- Services provided by a lay-midwife and home births

9.13 Dental Services

The following dental Services are not covered.

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

9.14 Services Covered Through Other Programs

There is no Coverage for services that are available to you under the following circumstances.

- Under an extended Benefits provision of any other health insurance or health Benefits plan, policy, program or benefit document;
- Under any other policy, program, contract or insurance as stated in Chapter 1, General Provisions, Section 3, "Other Party Liability"; (General Provisions is the chapter of this booklet that describes the rules of your Coverage)
- Under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, except where your Coverage is required by law to be your primary Coverage;
- Under any contractual, employment or private arrangement (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or hospital services;
- Emergency Services paid by foreign government public health programs;
- Any services whose costs are covered by third parties (including but not limited to, employer paid services such as travel inoculations and services paid for by research sponsors)

- Expense incurred by a Member; not a United States citizen; for services performed within the covered Member's home country; if the Member's home country has a socialized medicine program.

9.15 Alternate Services

Alternative Services are not covered. 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

Evaluations and office visits related to alternative services are not covered.

9.16 Vision Services

The following Vision Services or items are not covered:

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

9.17 Hearing Services

The following Hearing Services or items are not covered:

- Audiometric examination to evaluate hearing and measure hearing loss including, but not limited to, tests to measure hearing acuity related to air conduction, speech reception threshold, speech discrimination and/or a summary of findings
- Hearing aid evaluation assessment tests or exams to determine what type of hearing aid to prescribe to compensate for loss of hearing

- Hearing aid(s) to amplify sound and improve hearing
- Bone anchored hearing devices or surgically implanted bone conduction hearing aid
- Conformity evaluation test to verify receipt of the hearing aid, evaluate its comfort, function and effectiveness or adjustments to the hearing aid

