# Michigan State University

# Certificate of Coverage

# CERTIFICATE OF COVERAGE

## Blue Care Network

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 Blue Care Network ("BCN").

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

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

The 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 BCN 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 Certificate of Coverage Certificate of Coverage that conflict with MSU booklets, summaries or other benefit related documents.

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

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## *Definitions*

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

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

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

**Annual Coinsurance Maximum** means the maximum Coinsurance you will pay toward certain Covered Services provided Out-of-Network. Once you reach the Annual Coinsurance Maximum, you will not pay Out-of-Network Coinsurance for the services for the remainder of the calendar year.

**Approved Amount** is the lower of the billed charge or the maximum payment level BCN will pay for the Covered Services. Deductibles, Copayments and Coinsurance which may be required of you are subtracted from the Approved Amount before we make our payment.

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

**Balance Billing** is when a provider bills you for the difference between the provider's charge for a Covered Service 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 that your plan helps pay for as described in this Certificate.

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

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

**Certificate of Coverage** is this booklet that describes the Coverage available to you.

**Chronic** is a disease or ailment that lasts a long time or recurs frequently. Arthritis and heart disease, major depression and schizophrenia are examples of chronic diseases.

**Coinsurance** is your share of the costs of a Covered Service calculated as a percentage of the BCN Approved Amount that you owe after you pay any Deductible. This amount is determined based on the Approved Amount at the time the claims are processed or reprocessed and are not altered by an audit or


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recovery and are not reduced by any coupon, rebate or other credit received directly or indirectly from an assistance program. However, you may be able to take advantage of BCN-approved special coupon programs to help you pay some or all of your Coinsurance. The Coinsurance applies to the Out-of-Pocket Maximum.

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

**Coordination of Benefits (COB)** means a process of determining which Certificate of Coverage 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 or Copay** is a fixed amount you must pay for a Covered Health Service. You are usually required to pay the Copay at the time the service is rendered.

**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 may owe as defined in this Certificate of Coverage and any attached Riders. BCN pays the balance of the Allowed Amount for Covered Services.

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

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

**Deductible** is the amount that you owe for health care services before we pay. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed or reprocessed and are not altered by an audit or recovery and are not reduced by any coupon, rebate or other credit received directly or indirectly from an assistance program. However, you may be able to take advantage of BCN-approved special coupon programs to help you pay some or all of your Deductible. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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


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**Elective Abortion** is the intentional use of an instrument, or other substance or device to terminate a pregnancy that does not meet non-elective abortion guidelines as defined in Section 8 (Reproductive Care and Family Planning section).

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

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

**Experimental Treatment** is a treatment or drug that has not been scientifically proven to be as safe and effective for treatment of the member's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

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

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

**General Provisions** describes the rules of your health care Coverage.

**Grievance** is a written dispute about **C**overage determination or quality of care that you submit to BCN**.** For a more detailed description of the grievance process, refer to Section 3.4.

**Group** is Michigan State University (MSU).

**Group Health Plan** means the medical benefits plan provided by MSU.

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

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

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


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**Inter-Plan Programs** link participating health care providers and the independent Blue Cross Blue Shield companies across the country for claims processing and reimbursement. These programs are subject to Blue Cross® Blue Shield® Association policies and the rules set forth in this Certificate of Coverage. It allows BCN to have a variety of relationships with other Blue Cross and/or Blue Shield Licensees to process claims incurred in other states through the applicable Blue Cross® and/or Blue Shield® Plan.

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

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

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

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

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

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

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


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**Non-Participating Provider** is an individual, Facility, or other health care entity not under contract with BCN. Non-Participating Providers must be appropriately licensed to perform the Covered Health Service provided. Non-Participating Providers are not listed in the BCN Provider Directory. Services provided by a Non-Participating Provider are subject to the Out-of-Network Benefits unless otherwise stated in this Certificate. If a specific service requires Prior Authorization and the authorization is not received from BCN, the Non-Participating Provider may bill you for the service and you will be responsible for the entire bill.

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

**Online Visit** is a structured real-time online health consultation using secure audio-visual technology to connect with a professional provider in one location to a Member in another location. The Member initiates the medical or behavioral health evaluation. The Online Visit is for the purpose of diagnosing and providing medical or behavioral other health treatment for low-complexity non-emergent conditions within the provider's scope of practice.
**Open Enrollment Period** is a period of time set each year when eligible people may enroll or disenroll in BCN.

**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 apply higher Cost-Sharing than In-Network Benefits and may be subject to Balance Billing (unless otherwise noted).

**Out-of-Pocket Maximum** is the most you have to pay for In-Network Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your medical Deductible, Copayment and Coinsurance. This limit never includes your premium, Balance Billed charges, Out-of-Network Coinsurance, or health care services that BCN does not cover. Any coupon, rebate or other credit received directly or indirectly from an assistance program may not be applied to your Out-of-Pocket Maximum.

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

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

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


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

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

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

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Select MSU Nurse Practitioners

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

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

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

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


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

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

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

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

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

**Service Area** is the geographic area in Michigan in which BCN does business.

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

Skilled care services must be:

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

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

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

**Surprise Billing** is an instance where a Member unknowingly receives care from a Non-Participating Provider or receives care from a Non-Participating Provider because a Participating Provider is


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unavailable and later receives an unexpected bill for the difference between what the provider charges and what we pay. See Surprise Billing section under Chapter 1 for more about laws that protect you from Surprise Billing.

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

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

**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

MSU is responsible for determining eligibility. BCN does not make eligibility determinations, but updates its files to record eligibility information provided by MSU. Please contact the MSU benefits office 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.

  **NOTE:** If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this Certificate. This Certificate is not a Medicare Certificate. It is not intended to fill the gaps in Medicare Coverage and it may duplicate some Medicare benefits. If this Certificate is maintained, you will be responsible for the cost Medicare would have paid and you will incur larger out of pocket costs.
- **Change of Status:** You agree to notify the Group Health Plan within 30 days of any change in eligibility status of you or any Members on the Contract. When you are no longer eligible for Coverage, you are responsible for payment for any services or benefits.
- If you are admitted to a Hospital or Skilled Nursing Facility prior to the effective date of this Certificate of Coverage 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;
  - ✓ BCN 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.
- We will only pay for Covered Services you receive while you are a Member and covered under this Certificate and attached Riders. If you are admitted to a Hospital or Skilled Nursing Facility either when you become a Member or when your BCN Membership ends, BCN will only pay for the Covered Services provided during the time you are a Member. Once your Coverage under this Certificate ends, any attached Riders to this Certificate will automatically end without further action or notice by BCN.

## Section 2:  Other Party Liability

BCN does not pay claims or coordinate benefits for services that:

- Are not Preauthorized by BCN; or
- Are not Covered Services under this Certificate of Coverage

It is your responsibility to provide complete and accurate information requested by us to administer Section 2. Failure to provide requested information, including information about other Coverage, may


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result in denial of claims. If claims are denied due to your failure to update this information, the service will be considered a noncovered benefit and you may be responsible for the full amount of your provider's charges.

## 2.1 Nonduplication

- BCN Coverage provides you with benefits for health care services as described in this Certificate of Coverage.
- BCN does not duplicate benefits or pay more for Covered Health Services than the actual fees.
- Coverage described in this Certificate of Coverage 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 Certificate is a coordinated Certificate of Coverage. This means that for medical care needed as the result of an automobile accident, if the Member has a coordinated no-fault insurance policy, then BCN will assume primary liability for Covered Services. The no-fault automobile insurance would be secondary.

- If the Member has coverage through a non-coordinated (sometimes called a "full medical") no-fault automobile insurance policy, then the automobile insurance will be considered the primary plan. BCN would pay Coverage under this Certificate as the secondary plan.
- If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member's medical services. BCN would provide for Covered Services under this Certificate as the secondary plan.
- If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then the motorcycle insurance plan is primary. BCN would pay for Covered Services under this Certificate as the secondary plan.
- If the motorcycle insurance does not provide medical coverage or if that medical coverage is exhausted, then BCN will pay for Covered Services under this Certificate as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCN will pay secondary.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers' compensation law or program will not be paid by BCN.
- If any such services are paid or provided by BCN, BCN has the right to seek reimbursement from the other program, insurer or Member who has received reimbursement.
- Applicable BCN Preauthorization and Coverage requirements (i.e., seeking services from a Participating Provider except for Emergent situations) must always be followed for auto or work-related injuries. Failure to follow applicable Preauthorization and or Coverage requirements may leave you solely responsible for the cost of any services received.


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## 2.3 Coordination of Benefits (COB)

### Definitions

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

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

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

**Provisions per Michigan's Coordination of Benefits Act (MCL 550.253)**

**Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans**

(1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The health plan that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.

(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. A health plan that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.

(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.

(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the health plan that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the health plan that issued the primary plan.

**Order of Benefit Payments**

(2) The order in which benefits are payable by health plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(i) Except as otherwise provided in subparagraph (ii), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.

(ii) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395lll, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of


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benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(i) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the health plan that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the health plan has actual knowledge of the terms of the court order or judgment.

(B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (i).

(C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).

(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:

(I) The plan covering the custodial parent.

(II) The plan covering the custodial parent's spouse.

(III) The plan covering the noncustodial parent.

(IV) The plan covering the noncustodial parent's spouse.

(iii) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (i) or (ii), as applicable, as if those individuals were parents of the child.

(iv) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (i) to the dependent child's parents, as applicable, and his or her spouse.

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.

(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule


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described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.

(iii) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.

(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.

(iii) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(i) A change in the amount or scope of a plan's benefits.

(ii) A change in the entity that pays, provides, or administers the plan's benefits.

(iii) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

### Length of Time Covered under a Plan

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

### Plan Inability to Agree on Order of Benefits

(4) If the health plans cannot agree on the order of benefits within 30 calendar days after the health plans have received all of the information needed to pay the claim, the health plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment. A health plan is not required to pay more than it would have paid had the plan it issued been the primary plan.

### Amount to be Paid by the Secondary Plan

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the health plan that issued a secondary plan, if the health plan wishes to coordinate benefits, the health plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The health plan that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

**Amount to be Paid by the Secondary Plan**

(6) In determining the amount to be paid on a dental plan claim by the health plan that issued a secondary plan, if the health plan wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the health plan that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the health plan that issued the secondary plan shall make no payment. If a health plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

**Payment of Claims or Coordination of Benefits not Provided or Authorized by Health Maintenance Organization**

(7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract

## 2.4 Subrogation and Reimbursement

Subrogation is the assertion by BCN of your right, or the rights of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization. Reimbursement is the right of BCN to make a claim against you, your dependents or representatives if you or they have received funds or other valuable consideration from another party responsible for benefits paid by BCN.

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

"**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 BCN paid on behalf of the injured person.

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

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

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


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- Undisputed payment

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

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

### *Your Responsibilities*

In certain cases, BCN may have paid for health care services for you 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 BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a Lien or Right of Recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.
- You agree to inform BCN when your medical expenses should have been paid by another party but was not due to an act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your attorney of BCN's right and your obligations under this Certificate of Coverage.
- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining a written consent from BCN if payment was made for the treatment you received for that injury.
- You agree to cooperate with BCN in the efforts to recover money paid on your behalf.
- You acknowledge and agree that this Certificate of Coverage 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 BCN, its agents and the providers who treat you in accordance with state and federal privacy laws.


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

**BCN agrees** to keep this information confidential, and to ensure that BCN also maintains the confidentiality. This information will be used and disclosed only as authorized or required by law.

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

## 3.2 Inspection of Medical Records

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

## 3.3 BCN Primary Care Physician (PCP)

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

For children under the age of 18 ("Minors"), you may designate a Participating pediatrician as the Primary Care Physician if the Participating pediatrician is available to accept the child as a patient. Alternatively, the parent or guardian of a Minor may select a Participating family practitioner or general practitioner as the Minor's Primary Care Physician, and may access a Participating pediatrician for general pediatric services for the Minor (hereinafter "Pediatric Services").

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

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

If after reasonable efforts, you and the Primary Care Physician are unable to establish and maintain a satisfactory physician-patient relationship, you may be transferred to another Primary Care Physician. If a satisfactory physician-patient relationship cannot be established and maintained, you 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 Grievance Procedure

BCN and your Primary Care Physician are interested in your satisfaction with the services and care you

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

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

## *Definitions:*

**Adverse Benefit Determination** - means any of the following:

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

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

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

## *Step One*

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

Appeals and Grievance Unit
Blue Care Network
P. O. Box 44200
Detroit, MI 48244
Fax 866-522-7345

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

The individuals who review the first-level grievance are not the same individuals involved in the initial


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decision. If your grievance is denied, BCN will send you a written explanation of the reasons for denial and the next steps in the process. If the grievance is about a clinical issue, we'll send it for review to an independent medical consultant in the same or similar specialty as the doctor who provided the service.

### *Step Two: Review*

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

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

### *External Review by an Independent Review Organization*

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

**Mail: Appeals and Grievance Unit, Blue Care Network**
**P.O. Box 44200**
**Detroit, MI 48244**
**Fax: 1-866-522-7345**

### *External Review by the Department of Insurance and Financial Services*

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

| | |
|---|---|
| **Mail:** | **P.O. Box 30220**<br>**Lansing, MI 48909-7720** |
| **Personal delivery:** | **530 W. Allegan Street, 7th floor**<br>**Lansing, MI 48933-1070** |
| **Phone:** | **1-877-999-6442** |
| **Fax:** | **517-284-8837** |
| **Online:** | Email: DIFS-HealthAppeal@michigan.gov<br>(Blue Care Network doesn't control this website and isn't responsible for its content.) |


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### 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 BCN member ID card.

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

## 3.5 Additional Member Responsibilities

You have the responsibility to:

- Read this Certificate of Coverage and all Group Health Plan documents, and call Customer Service 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 BCN and Providers need to provide you with care.
- Make and keep appointments for non-emergent medical care. You must call the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and 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, as applicable, Group Health Plan, or BCN requests. You represent that any information you submit is true, correct and complete. The submission of false or misleading information relating to 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 Certificate of Coverage or by contacting Customer Service at the number provided on the back of your ID card.

## 4.2 Identification Card

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

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


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

### 4.3 Enrollment Records

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

### 4.4 Authorization to Receive Information

By accepting Coverage described under this Certificate of Coverage, you agree that:

- BCN may obtain any information from providers relating to Coverage.
- BCN may disclose any of your medical information to your Primary Care Physician or other treating physicians as permitted by state and federal law.
- 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 Health Services other than applicable Deductible, Copayments  or Coinsurance. If, however, circumstances require that you pay a provider, you may request reimbursement for those Covered Health Services. Proof of the payment must show exactly what Services were received including diagnosis, procedure codes, date and place of service. A billing statement that shows only the amount due is not sufficient.

Additional information regarding the process for submitting a claim for reimbursement and the Reimbursement Form are available at https://www.bcbsm.com/. You may submit your itemized medical bills electronically through your Member online account or mail to the address below.

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

**NOTE:** Proof of payment must be submitted within 12 months of the date of service. Any claim submitted 12 months after the date of service will not be reimbursed by BCN.

## Section 5: Termination of Coverage

### 5.1 Termination of Group Coverage

Coverage described in this Certificate of Coverage 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 BCN to terminate the ASC. Coverage for Members will terminate on the date the ASC is terminated as permitted by law.


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## 5.2 Termination for Nonpayment

<u>Nonpayment by the Group</u>

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

<u>Nonpayment of Member Cost Sharing</u>
BCN may terminate Coverage under the following conditions:

- If you fail to pay your Cost Sharing (Copays or Coinsurance) 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

The termination will be effective upon 60 days' notice by BCN.

## 5.3 Termination of a Member's Coverage

<u>Termination</u>
Coverage may also 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 the Group Health Plan for payments we made for services that were not a benefit under this Certificate, subject to your rights under the appeal process
- You are satisfying a civil judgment in a case involving BCN
- You are repaying the Group Health Plan funds you received illegally
- You are serving a criminal sentence for defrauding BCN
- Your group changes to a non-BCN health plan
- The Group Health Plan no longer offers this coverage

<u>Rescission</u>
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, BCN will consider you in breach of contract and, upon 30 days written advance notice, your membership may be Rescinded. Once we notify you that we are rescinding your Coverage, we may hold or reject claims during this 30-day period. Your Coverage may be rescinded back to the beginning of your membership. In some circumstances, fraud or intentional misrepresentation of a material fact may include:

- Misuse of the BCN ID card (Section 4.2)
- Intentional misuse of the BCN system
- Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCN complaint and grievance procedure. You can find this procedure in your Certificate of Coverage, on our website at https://www.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. 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. You may contact BCN customer service for information on Blue Care Network of Michigan, Inc. or Blue Cross® Blue Shield® of Michigan.

### 6.2 COBRA Coverage

If you no longer meet the eligibility requirements as defined by Michigan State University, 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 BCN 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 BCN is required to give to you will be:

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

## 7.2 Change of Address

You must notify MSU and BCN immediately if your address changes. You must live in the Service Area at least six months out of each Calendar year.

## 7.3 Heading

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

## 7.4 Execution of Contract of Coverage

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

## 7.5 Assignment

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

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


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## 7.6 Policies

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

## 7.7 Time Limit for Legal Action

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

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

## 7.8 Your Contract

Your contract consists of the following:

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

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

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

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

## 7.9 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 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 BCN has the authority to bind BCN by making promises or representations, or by giving or receiving any information.


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## 7.10 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 BCN or by mutual agreement between the MSU, Group Health Plan and BCN.

## 7.11 Major Disasters

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

If facilities and personnel are not available, causing delay or lack of services, BCN will be excused from performing services in support of Coverage so long as the circumstances continue.

Such circumstances include but are not limited to:

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

## 7.12 Obtaining Additional Information

The following information is available:

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

- You can obtain the information through these sources:
  - ✓ Online at https://www.bcbsm.com/
  - ✓ By writing BCN Customer Service at P.O. Box 68767, Grand Rapids, MI 49516-8767
  - ✓ By calling our Customer Service Department at the number shown on the back of your BCN ID card
  - ✓ By checking your BCN Welcome book


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

## *7.13 Right to Interpret Contract*

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

## *7.14 Inter-Plan Programs*

If you receive Covered Services in another state, the claims will be processed through the Inter-Plan Programs. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

Overview

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

Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCN remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

Inter-Plan Programs Eligibility – Claim Types

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

**A. Inter-Plan Programs**

Under the Inter-Plan Programs, when you access Out-of-Area Covered Healthcare Services outside the BCN Service Area, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.


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The financial terms of the Inter-Plan Programs are described generally below.

**Liability Calculation Method Per Claim**

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

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

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

(ii) Estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

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

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

**B. Nonparticipating Providers Outside of the BCN Service Area**

1. Member Liability Calculation

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


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Covered Healthcare Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

2. Exceptions

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

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

**C. Blue Cross Blue Shield Global Core**

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

- **Inpatient Services**

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

- **Outpatient Services**

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


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

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

**D. Exclusions and Limitations**

This addendum will not apply if:

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

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

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

## 7.15 Unlicensed and Unauthorized Providers

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

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

## 7.16 Special Programs

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

When special programs are available, you must enroll in and use the program when required by BCN or the approved vendor. For example, you may be required to enroll in and use programs provided by the drug manufacturers or affiliates to receive coupons or assistance for select medications.

Special programs may lower the cost typically associated with medical services and medications. Participating in certain special programs may result in you paying less than your plan Cost-Share. If


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you choose not to participate or are not eligible to participate in the program, you will pay the applicable Cost-Share for the services defined in this Certificate and associated Riders.

**NOTE:** Only the amount you pay out of pocket will apply towards your annual Out-of-Pocket Maximum.

We may terminate any special program based on:

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

You may access information on these programs by contacting BCN Customer Service.

## 7.17 Surprise Billing

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

The following situations are covered by the Surprise Billing laws:

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

## 7.18 EXPERIMENTAL TREATMENT

We do not pay for:

- Experimental treatment. This includes experimental drugs and devices
- Services and administrative costs related to experimental treatment
- Costs of research management


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**NOTE:** See Clinical Trials section and Covered Services below for exceptions.

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

## How BCN Determines if a Treatment is Experimental

If a treatment is not covered under this Certificate, BCN's Medical Director will determine if it is experimental. The director may decide it is experimental if:

- Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
- It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the member's condition, or
- Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or
- It is being studied in an on-going clinical trial, or
- The treating provider uses a written informed consent that refers to the treatment as:
    - Experimental or investigational, or
    - Other than conventional or standard treatment, or
    - The Medical Director may consider other factors

## How BCN Determines if a Drug is Experimental

BCBSM/BCN Pharmacy and Therapeutics (P&T) Committee determines whether a drug is experimental. The committee may decide whether a drug is experimental if there is insufficient evidence of a clinical benefit for the indication(s) in question. A drug may be deemed experimental if any of the following apply:

- The drug does not have unrestricted market approval from FDA for the requested use
- There is insufficient medical and scientific evidence to evaluate the therapeutic value of the drug for the requested use
- There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the drug has a beneficial effect on health outcomes; for example, when a drug does not meet its primary endpoint in a pivotal or confirmatory trial
- The drug is not as beneficial as established alternatives or there is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the drug is as beneficial as established alternatives.

When available, these sources are considered in deciding if a treatment or drug is experimental under the above criteria:

- Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)


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- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
- Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
- Accepted national standards of practice in the medical profession
- Approval by the hospital's or medical center's Institutional Review Board

**NOTE:** The Medical Director may consider other sources

## Coverage

We do cover experimental treatment and its related services including drugs 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 services related to the experimental treatment are covered under your Certificate when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCN-approved clinical trial (check with your provider to determine whether a clinical trial is approved by BCN), or the related services are routine patient costs that are covered under "Clinical Trials" section.

## Limitations and Exclusions

- This general provision does not add Coverage for services not otherwise covered under your Certificate.
- Drugs or devices given to you during a BCN-approved clinical trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, we will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.


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# CHAPTER 2 - YOUR BENEFITS

## Section 8:  Your Benefits

IMPORTANT INFORMATION

- Your health care benefits are provided as a part of the Group Health Plan.  Blue Care Network ("BCN") has contracted with MSU to administer your Coverage.
- As discussed in the introduction of this Certificate of Coverage, BCN provides 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 except in an emergency.
- Medical Services defined in this Certificate  are Covered  Services only when they are Medically Necessary.
- Coverage is subject to the limitations and exclusions listed in this Chapter.
- You are responsible for Deductible, Copayments 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  Preauthorization is not a guarantee of payment. All claims are subject to:
  - Review of the diagnosis reported
  - Verification of Medical Necessity
  - Availability of Benefits at the time the claim is processed
  - Conditions, limitations, exclusions, maximum
  - Coinsurance, Copayments, and Deductible under your Certificate and Riders
- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.
- If you purchase a deluxe item or equipment  when not Medically Necessary, the Approved Amount for the basic item applies toward the price of the deluxe item. You are responsible for any costs over the Approved Amount.
- For an updated list of Services that require Preauthorization, contact Customer Service at the number shown on the back of your BCN ID card or by visiting https://bcbsm.com/priorauth.
- You can find information about other Benefits as listed below, in your member account at https://www.bcbsm.com/
  - Disease management
  - Prevention
  - Wellness
  - Care management services

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

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


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You must select a BCN Primary Care Physician to provide or coordinate your In-Network Covered Services.

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

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

- Provided or coordinated by your Primary Care Physician or Participating Provider in the office, in the home or at a Participating Provider – either Inpatient or Outpatient – with any required authorization.
- Provided by a Participating Provider with any required Preauthorization, but without coordination with the Primary Care Physician
- Provided by a Non-Participating Provider when there is an insufficient number of Participating Providers for a specific provider specialty within the BCN provider network. The service must be Preauthorized by BCN for the In-Network Cost Share to apply. If Prior Authorization is not received before you receive Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for paying the Out-of-Network Cost Sharing when received from a Non-Participating Provider.
- Emergency health services
- Urgent care center services
- Provided outside of Michigan utilizing the Inter-Plan Programs (See Section 7.13 Out of Area Services)

**NOTE:** You are responsible for determining whether a provider is a Participating Provider before obtaining services. This information can be found at https://www.bcbsm.com/or by contacting Customer Service at the number provided on the back of your BCN ID card. Unless otherwise specified in this Certificate and the Surprise Billing section, we pay claims based on the status of the provider as of the date of service.

**Out-of-Network Benefits** are generally paid at a lower rate than In-Network Benefits or may be excluded from Coverage. You may be responsible for the difference between the Approved Amount and the Non-Participating Provider's charge. (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference).

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
- Preauthorized by BCN if Preauthorization is required. For a complete list of services requiring Preauthorization, contact customer service or visit https://www.bcbsm.com/priorauth. For these services, coordinate the authorization through BCN and the Non-Participating Provider.

- Provided outside of Michigan without utilizing the Inter-Plan Programs (See Section 7.13 Out of Area Services)

**NOTE**: You must notify BCN before receiving certain Covered Health Services from a Non-Participating Provider. Notification requirements are detailed below with respect to applicable benefits.

## 8.2 Cost Sharing

### Deductible

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

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 calendar year.

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

Your Deductible renews each calendar year. It does not carry over into the new year.
If you use both In-Network and Out-of-Network Benefits, separate Deductible amounts apply. The Deductible for In-Network and Out-of-Network Benefits is not combined to satisfy the Deductible limit.

| Deductible | |
|---|---|
| **In-Network** | **Out-of-Network** |
| $175 per Member per calendar year<br>$350 per contract per calendar Year<br>✓ Applies toward the In-Network Out-of-Pocket Maximum | $500 per Member per calendar year<br>$1,000 per contract per calendar year<br>✓ Applies toward the Out-of-Network Out-of-Pocket Maximum<br>✓ Does not apply toward Annual Coinsurance Maximum |

### COPAYMENT

You are responsible for fixed dollar Copayments for many of the Benefits listed in this Certificate of Coverage. You are required to pay any Copayments at the time you receive the services. In-Network Copayments count toward your In-Network Out-of-Pocket Maximum. Once your In-Network Out-of-Pocket Maximum is met, you will not be responsible for In-Network Copayments for the remainder of the calendar year.

Out-of-Network Copayments do not apply to either the annual Out-of-Pocket Maximum or the Annual Coinsurance Maximum.

### COINSURANCE

You are responsible for a percentage of the Approved Amount (Coinsurance) for many of the Benefits listed in this Certificate of Coverage. Your Coinsurance is dependent upon the In-Network or Out-of-Network services that you receive. Coinsurance amounts apply after the Deductible has been met.


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Please refer to the tables below and the specific section in this Certificate of Coverage to determine your Coinsurance responsibility.

| Coinsurance | |
|---|---|
| **In-Network** | **Out-of-Network** |
| 20% and 50% of the In-Network Approved Amount after In-Network Deductible for select services<br>✓ Applies toward In-Network Out-of-Pocket Maximum | 20% and 50% of the Out-of-Network Approved Amount after Out-of-Network Deductible for select services<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum |

**Cost Sharing – Deductible, Coinsurance and Copayment Calculation**

If you have a Coinsurance or a Copayment for a particular Service as well as a Deductible, you will first be responsible for the payment of the Deductible. The Coinsurance or Copayment will be based on the remaining balance of the Approved Amount. BCN will be responsible to make payment to the provider only after the Deductible, Coinsurance, and Copayment have been paid. Cost Sharing met In-Network is not combined with Cost Sharing met Out-of-Network.

## *In-Network Out-of-Pocket Maximum*

The Out-of-Pocket Maximum is the most you will pay for In-Network Covered Services under this Certificate of Coverage and any applicable Riders per calendar year. The Out-of-Pocket Maximum includes your In-Network medical Deductible, Copayment and Coinsurance.

Specific In-Network Services defined under this Certificate of Coverage apply to the Out-of-Pocket Maximum.

Once you reach the Out-of-Pocket Maximum, you will not pay Cost Sharing for In-Network Covered Services for the remainder of the calendar year with the following exceptions:

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

| In-Network Out-of-Pocket Maximum | |
|---|---|
| **In-Network** | **Out-of-Network** |
| $3,000 per Member per calendar year<br>$6,000 per contract per calendar year | Does not apply |

**NOTE**: Your Out-of-Pocket Maximum as defined in this Certificate of Coverage applies to medical Cost Sharing only and does not include your pharmacy Cost Sharing. Medical and pharmacy Out-of-Pocket Maximums are separate.


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### *Out-of-Network Annual Coinsurance Maximum*

Covered Services provided Out-of-Network apply toward the Annual Coinsurance Maximum. Once your reach the Out-of-Network Annual Coinsurance Maximum, you do not pay Out-of-Network Coinsurance for the remainder of the calendar year.

Deductible amounts, flat dollar Copayments and services with a 50% Coinsurance do not apply toward the Annual Coinsurance Maximum.

| Annual Coinsurance Maximum | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Does not apply | $3,000 per Member per calendar year<br>$6,000 per contract per calendar year |

If you use both In-Network and Out-of-Network services, separate Out-of-Pocket Maximum and Annual Coinsurance Maximums apply. Out-of-Pocket Maximum for In-Network and Annual Coinsurance Maximum for Out-of-Network Benefits are not combined to satisfy either the Out-of-Pocket Maximum or the Annual Coinsurance Maximum limit.

## *8.3 Balance Bills*

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

Out-of-Network Benefits: You may be responsible for amounts charged by a Non-Participating Provider that exceed the Approved Amount. (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference)

## *8.4 Medical Professional Physician Services*

a) ***Office Visits*** - including outpatient office site, hospital location or Online Visit

- Primary Care Physician (PCP)
- OB/GYN
- Specialist physician
- Online Visit

  We cover Online Visits by a professional provider to:

  – Diagnose a condition
  – Make treatment and consultation recommendations
  – Write a prescription, if appropriate
  – Provide other medical or health treatment

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


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**Online visits with the BCN Online Visit vendor are not covered.**

**NOTE**: Not all services delivered virtually are considered an online visit, but maybe considered telemedicine. Telemedicine services will be subject to the applicable Cost Share associated with the service provided.

***Online Visit exclusions include but are not limited to***

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

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

| Office Visit Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| $25 Copayment per visit<br>$25 Copayment per Online visit when performed by the PCP or specialist physician<br>$25 Copayment for Specialist visit<br>✓ Applies toward In-Network Out-of-Pocket Maximum | Primary Care Physician - Not applicable<br>Consulting specialist care other than preventive services – 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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

| Maternity Care Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Routine prenatal and postnatal visits are covered in full<br>See Preventive and Early Detection Services section<br>We cover maternity education when provided by your PCP, Participating OB/GYN or Participating Certified Nurse Midwife. | **Prenatal and postnatal care**- 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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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 | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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 | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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

| Allergy Care Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full<br>✓ Office visit Copayment may apply per Member per visit | 20% Coinsurance of the Approved Amount after Out of Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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f) ***Chiropractic Services and Osteopathic Manipulative Therapy*** when provided In Network by a BCN Participating Chiropractor or Physician and Preauthorized by BCN

### *Coverage*

- When an office visit and a spinal manipulation are billed on the same day by the same provider, only one Copay will be required for the office visit.
- Mechanical traction once per day is covered when it is performed with chiropractic spinal manipulation.
- Radiological Services and X-rays are covered when Preauthorized.

See Outpatient Services section 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 24 visits per Member per Calendar Year. The 24-visit limit is combined whether the manipulations are performed by a Chiropractor or an osteopathic provider.

Visits for mechanical traction are applied toward your Benefit Maximum for physical, speech, and occupational therapy Services. The therapies (mechanical traction or physical, speech, and occupational therapy) are limited to the Benefit defined under Section 8.17 Outpatient Rehabilitation.

| Chiropractic Services and Osteopathic Manipulative Therapy Cost Sharing | |
|---|---|
| In-Network | Out-of-Network |
| $25 Copayment for each office visit<br>✓ Applies toward In-Network Out-of-Pocket Maximum | ✓ Not covered |

. ***G) Medical Services at a Pharmacy***

Covered services performed by a pharmacist, which may include certain medical evaluations and testing, when performed at a BCN affiliated immunization pharmacy. When services are received at a non-immunization affiliated pharmacy, the services are not covered.

| Medical Services At A Pharmacy Cost-Sharing | |
|---|---|
| In-Network Benefits | Out-of-Network Benefits |
| Evaluations are covered the same as the Primary Care Physician office visits. | Not Covered |
| **NOTE**: An affiliated immunization pharmacy can be found through the Find Care option through your BCBSM secured member account. | |


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## 8.5 Continuity of Care for Professional and Facility Services

### Continuity of Care for Existing Members

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

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

Provider Requirements

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

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

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

Complex Medical Conditions

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

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

### Coverage

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


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at the In-Network Level, your Participating Primary Care Physician must provide or coordinate all such Services.

## *Continuity of Care for New Members*

If you are a new Member and want to continue an active course of treatment from your existing, Non-Participating Provider, you may request enrollment in BCN's Continuity of Care program. At the time of enrollment, you must select a BCN 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 circumstances described below. You have up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider.

<u>Complex Medical Conditions</u>

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

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

## *Coverage*

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

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

## *8.6 Preventive and Early Detection Services*

We cover Preventive and Early Detection services as defined by the federal Patient Protections and Affordable Care Act (PPACA). These Services must be provided or coordinated by your Primary Care Physician. Services may be modified by the federal government from time to time.

Preventive Services include but are not limited to the following:

a) **Health assessments, health screenings and adult physical examinations** at intervals set in


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relation to your age, sex and medical history. Health screenings include but are not limited to:

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

| In-Network Benefits | Out-of-Network Benefits |
| --- | --- |
| Covered in full | Not Covered |

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

**We follow PPACA guidelines consistent with the HRSA-Supported Women's Preventive Services Guidelines for the following services:**

- Gynecological (well-woman) examinations including routine pap smear
- Screening mammography*- One per Member per Calendar Year to screen for breast cancer
    - Additional breast cancer screening services, such as an ultrasound, may be required to address findings from the initial screening mammography. Each of the additional services are covered as preventive if received within 12 months of a screening mammography but not more than one per year.
- Screening for sexually transmitted diseases; HIV counseling and screening
- Contraceptive counseling and methods including measurement, fittings, insertion, removal, administration and management of contraceptive care for Members as required by PPACA and consistent with HRSA-Supported Women's Preventive Services Guidelines. FDA approved contraceptive methods include:
    - Contraceptive devices and appliances such as intrauterine devices (IUDs)
    - Implantable and injected drugs such as Depo-Provera and diaphragms
    - Contraceptive mobile app; one annual membership (12 consecutive months) per Member
        - When you purchase a yearly subscription for an FDA-approved contraceptive mobile app, log into your Member account at https://www.bcbsm.com to find and fill out a reimbursement form. Submit the form along with your receipt for reimbursement. BCN will reimburse you up to charge for your yearly subscription.
- Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling, and alternative fertility awareness methods
- Breast pump and associated supplies needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. (See Durable Medical Equipment section for limitations and exclusions)
- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening
- Screening for gestational diabetes


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- Bone Density Screening for osteoporosis to prevent fractures
- Genetic counseling and BRCA testing if appropriate for Members whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes
- Sterilization procedures for Members with female reproductive organs such as tubal ligation and related charges associated with the procedure (anesthesia, labs, ect.)
- Screening and counseling for intimate partner and domestic violence

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered<br><br>*Mammography screening is covered: 20% Coinsurance of the Approved Amount after Out-of-Network Deductible; may require Preauthorization<br><br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |

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

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |
| Flu shots and travel inoculations are covered in full In-Network and Out-of-Network. | |

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

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |

Other nutritional counseling services may be covered when Preauthorized by your Primary Care Physician and BCN.

**NOTE:** Certain health education and health counseling services may be arranged through your Primary Care Provider, but are not payable under your Certificate of Coverage. Examples include but are not limited to lactation classes not provided by your physician, weight loss programs, tobacco cessation programs (other than a BCN tobacco cessation program), and/or exercise classes.

g) **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.)

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Routine colonoscopy is covered: 20% Coinsurance of the Approved Amount after Out-of-Network Deductible; may require Preauthorization<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum<br><br>*All other routine cancer screenings - Not Covered* |

g) **Depression Substance Use Disorder/chemical dependency screening**

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |

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

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |

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

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Covered in full | Not Covered |

**NOTE**: Deductible, Copayment and/or Coinsurance (Cost Sharing) will apply to non-routine diagnostic procedures. If this Certificate of Coverage is amended by Cost Sharing Riders, the applicable Rider will take precedence over the Certificate of Coverage. Office Visit Cost Sharing 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.


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

## 8.7 Inpatient Hospital (Facility) Services

The following Inpatient Hospital (Facility) Services are covered when determined to be Medically Necessary and Preauthorized by BCN. (Benefits for Physician Services are described under Professional Physician Services section.) Services include but are not limited to the following:

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

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

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

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

- Newborn care

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

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

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


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Newborn Care includes:

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

**The baby must be eligible for coverage and must be added to your contract within the eligibility timeframe set by Michigan State University.**

| Inpatient Hospital (Facility) Services Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible when Medically Necessary and Preauthorized by your Primary Care Physician and BCN | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible when Medically Necessary and Preauthorized by BCN<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

**NOTE:** Certain hospital services have separate requirements and your Cost Sharing may be different. (See, for example, Coverage for emergency care and reproductive care.)

See section 8.4 for Inpatient Professional Services Cost Sharing

## 8.8 Outpatient Services

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

You receive Outpatient Services in these places:

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

Outpatient Services include but are not limited to:

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


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| Outpatient Services Cost Sharing<br>Facility and Professional Services | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible when Medically Necessary and Preauthorized by your Primary Care Physician and BCN | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible when Medically Necessary and Preauthorized by BCN<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

**NOTE**: Outpatient diagnostic laboratory and pathology tests are covered in full; Deductible does not apply.

**NOTE:** Certain outpatient services have separate requirements and your Cost Sharing may be different. (See, for example, Coverage for emergency care and reproductive care.)

**NOTE**: Out-of-Network Benefits for preventive health procedures are not covered.

## 8.9 Emergency and Urgent Care

### Definitions

- **Accidental Injury** - a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health. 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** – Whether a condition is a "Medical Emergency" does not depend on a particular diagnosis. Instead, it is based on the sudden onset of a serious medical condition resulting from injury, sickness or behavioral health condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant Member, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
- **Stabilization** - the point at which 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 and Urgent Care Services are covered up to the point of Stabilization when they are Medically Necessary and needed either 1) for immediate treatment of a condition that is a Medical

Emergency as described above or 2) if the 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. Admission to the hospital after a Medical Emergency has been stabilized requires Authorization by BCN. However, Prior Authorization is not required for you to obtain Emergency Services.

Emergency Services include professional and related ancillary services and Emergency Services provided in an urgent care center, Hospital emergency room or independent freestanding emergency department. Emergency Services are covered regardless of whether the provider of Facility is participating.

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

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

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

| **Emergency Services and Urgent Care Copayment** | |
|---|---|
| **In-Network** | **Out-of-Network** |
| • $250 for Emergency Services provided in a hospital emergency room<br>• $30 for Emergency Services in an Urgent Care Center<br><br>Applies toward In-Network Out-of-Pocket Maximum | • $250 for Emergency Services provided in a hospital emergency room<br>• $30 for Emergency Services in an Urgent Care Center<br><br>Applies toward Out-of-Network Out-of-Pocket Maximum |

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

If you are admitted as an Inpatient as a result 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 the Inpatient Hospital Services Section.


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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.

### *Emergency Services at a Non-Participating Hospital*

If you are hospitalized in a Non-Participating Hospital, we may require that you be transferred to a Participating Hospital as soon as you are stabilized. If you refuse to be transferred, you may be required to sign a notice and consent form by the Non-Participating Hospital. If you sign this form, all related non-emergency Covered Services will be covered at the Out-of-Network Benefit level from the date of when the from was signed.

### *Out-of-Area and Non-Participating Provider Coverage*

You are covered when traveling outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above. (See Sections 7 and 9 for additional information.)
When Services are rendered by a Non-Participating Provider, we a rate based on the requirements of state and federal laws.

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

## *8.10 Ambulance*

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

For **ground ambulance**, a covered destination may include:

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

For **air ambulance**, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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

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

- The service must be Medically Necessary. Any other means of transport would endanger the Member's health or life


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- Coverage only includes the transportation of the Member and whatever care is required during transport. Other services that might be billed with the transportation is not covered
- The service must be provided in a licensed ground or air ambulance that is part of a licensed ambulance operation

**Coverage also includes when:**

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

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

Air ambulance

Air Ambulance services must also meet these requirements:

- No other means of transport are available
- The Member's condition requires transportation by air ambulance rather than ground ambulance
- – An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.
- Non-Emergent air ambulance services must be approved before they occur. If they are not Preauthorized, they will be considered a noncovered benefit and you may have to pay the entire cost. It is important to make sure your provider gets approval before you receive services.
- – The Member is transported to the nearest facility capable of treating the Member's condition.

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

| Ambulance Cost Sharing | |
|---|---|
| In-Network | Out-of-Network |
| 20% Coinsurance after the In-Network Deductible<br>• Applies toward In-Network Out-of-Pocket Maximum | 20% Coinsurance after the In-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum |

## Exclusions include but are not limited to

- Transportation or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services


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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.

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

## 8.11 Reproductive Care and Family Planning Services

We cover the following:

- Infertility
- Voluntary Sterilization
- Termination of Pregnancy
- Genetic Testing
- Fertility Preservation

### a) Infertility

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

| Infertility Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| 50% of the Approved Amount after In-Network Deductible for all fees associated with infertility diagnostic work-up procedures, treatment and all facility, professional and related services.<br>✓ Applies toward In-Network Out-of-Pocket Maximum | 50% Coinsurance of the Approved Amount after Out-of-Network Deductible for all fees associated with facility, professional and related services when Preauthorized by BCN.<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Does not apply to Annual Coinsurance Maximum |

**Exclusions include but are not limited to:**

- Harvesting
- Storage or manipulation of eggs and sperm

  NOTE: Manipulation of sperm such as sperm washing is covered when associated with artificial insemination for Members with an infertility diagnosis.
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- In-vitro fertilization procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT


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(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
- Prescription drugs

b) ***Voluntary*** **Sterilization**
Coverage includes Inpatient; Outpatient and office based adult sterilization Services.

| **Sterilization of Female Reproductive Organs Cost Sharing**<br>As defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services (See Preventive and Early Detection Services section). | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full | Not covered |

| **Sterilization of Male Reproductive Organs Cost Sharing** | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | Not covered |

**Exclusion includes but is not limited to**:

- Reversal of surgical sterilization

c) **Termination of Pregnancy**
First trimester 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** | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible when Preauthorized by BCN | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible when Preauthorized by BCN<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

**NOTE:** If the termination of pregnancy is not legal in the location where the service is being rendered, such abortions are an exclusion in that location.

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.


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| Genetic Testing Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| $25 Copayment for each office visit<br><br>✓ Applies toward In-Network Out-of-Pocket Maximum | 20% Coinsurance of the Approved Amount after Out of Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

**Exclusion includes but is not limited to:**

- Genetic testing and counseling for non-members

## Fertility Preservation

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

We cover the following procedures for fertility preservation:

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

## Cost Sharing

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| Your In-Network Inpatient and Outpatient Cost Share applies to fertility preservation procedures including office consultations, diagnostic and surgical services. | Your Out-of-Network Inpatient and Outpatient Cost Share applies to fertility preservation procedures including office consultations, diagnostic and surgical services. |

## Exclusions include but are not limited to:

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


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## 8.12 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 | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |
| Limited to 100 days per Calendar Year In-Network and Out-of-Network combined | |

**NOTE**: The maximum number of benefit days per Calendar Year received In-Network and Out-of-Network are combined. For example, use of a benefit day under In-Network will reduce the benefit days available Out-of-Network.

### Exclusions include but are not limited to

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

## 8.13 Home Health Care Services

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

Home Health Care must be:

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

### Coverage

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy (NOTE: Outpatient therapy limits as defined in Outpatient Rehabilitation section do not apply)
- Other health care services approved by BCN when they are performed in the Member's home


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| Home Health Care Services Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |
| Limited to 60 days per Calendar Year In-Network and Out-of-Network combined | |

### *Exclusions include but are not limited to*

- Housekeeping services
- Custodial Care (See Section 9)

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

### *Coverage*

- 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
- Respite care in a Facility setting

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

| Hospice Care Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible |


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| | |
|---|---|
| | ✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

### 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

## 8.15 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 Facility).

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

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

### Coverage

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

| Home Infusion Therapy Services Care Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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

### A) Mental Health Care

We cover evaluation, consultation and treatment necessary to determine a diagnosis and treatment for mental health conditions that are in accordance with generally accepted standards of practice. Non-Emergency Mental Health Services may require Preauthorization. For a list of services requiring Preauthorization, contact Customer Service or visit https://bcbsm.com/priorauth. (Mental Health Emergency Services are covered pursuant to Emergency and Urgent Care section.)

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

### Definitions

- **Inpatient Mental Health Service** is the service provided during the time you are admitted to a BCN approved acute care Facility that provides continuous 24-hour nursing care for comprehensive treatment.
- **Residential Mental Health Treatment** is a state-licensed Facility that allows for 24-hour domicilary care and supervision for safety. The Facility provides continuous treatment by or under the supervision of a qualified professional provider 24/7 with a response time to the Facility in case of emergency within 60 minutes. Residential treatment is:
  - Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program
  - A structured environment that will allow the individual to reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long-term means of protecting others in the Member's usual living environment
  - Not based on a preset number of days such as standardized program (i.e., "30-Day Treatment Program")
  - The treatment is managed by a multidisciplinary treatment team and reviewed regularly with the Member and team at least weekly
- **Partial Hospitalization Mental Health** is a comprehensive, acute care program that consists of a minimum of 4 hours per day, at least 3 days a week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluation and other Services as needed.
- **Intensive Outpatient Mental Health** services are Acute Care Services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 3 days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and other Services as needed.
- **Outpatient Mental Health** services include individual, conjoint, family or group psychotherapy, psychiatric evaluation, counseling, medical testing and crisis intervention.

### Coverage

Mental health care is covered in either an Inpatient or Outpatient setting. To obtain Services call the


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mental health treatment number shown on the back of your BCN ID card. They are available 24 hours a day, 7 days a week.

| Inpatient Mental Health/ Mental Health/Partial Hospitalization Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |
| **Outpatient Mental Health/Intensive Outpatient Mental Health Cost Sharing** | |
| **In-Network** | **Out-of-Network** |
| Covered in full no matter the location including online visits | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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

See Section 9 for Exclusions and Limitations.

### B) Substance Use Disorder

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

Non-Emergency Substance Use Disorder treatment may require Preauthorization by BCN. For a list of services requiring Preauthorization, contact Customer Service or visit https://bcbsm.com/priorauth. Emergency Services are covered pursuant to Emergency and Urgent Care services section (See Section 8.8).

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

### Definitions

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

**Residential Substance Use Disorder Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical hospitalization. Residential services may include 24-hour professional supervision and may include

counseling, Detox, medical testing, diagnostic and medication evaluation and other Services as needed. Residential Substance Use Disorder Treatment is sometimes referred to as Intermediate Care. Residential Substance Use Disorder is not considered inpatient -acute medical/surgical care in a hospital.

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

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

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

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

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

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

## Coverage

We cover Substance Use Disorder Services including counseling, medical testing, diagnostic evaluation and Detox are covered in a variety of settings. To obtain Services call the Substance Use Disorder Treatment number shown on the back of your BCN ID card. They are available 24 hours a day, 7 days a week.

| **Detox/Residential/Intermediate Care/Partial Hospitalization/Partial Domiciliary Substance Use Disorder Cost Sharing** | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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| Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

**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 Rehabilitation

Outpatient Therapy and 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
- Speech therapy
- Chiropractic and Osteopathic mechanical traction
- Biofeedback for treatment of medical diagnosis when Medically/Clinically Necessary, as determined according to BCN medical policies.

We cover **Short-term Outpatient therapy** and medical rehabilitation Services including speech therapy when meeting the following criteria:

- Preauthorized by BCN as Medically Necessary
- Treatment for recovery from surgery, disease or injury
- Provided in an Outpatient setting
- Services for conditions that are generally required to be provided through publicly supported programs, public agencies or schools
- Services are not provided or funded by any federal or state agency or any local political subdivision, including school districts
- Results in meaningful improvement in your ability to do important day to day activities within 60 days of starting treatment

| Outpatient Rehabilitation Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| $20 Copayment for each visit<br>✓ Applies toward In-Network Out-of-Pocket Maximum | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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| | |
|---|---|
| Limited to 60 combined visits per calendar year | |

## Benefit Maximum

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

The Benefit Maximum renews each Calendar Year.

The limit for outpatient therapy services provided In-Network and Out-of-Network are cumulative. For example, use of a visit In-Network will reduce the visits available Out-of-Network.

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

## General exclusions include but are not limited to

- Cognitive therapy and retraining (neurological training or retraining)
- Vocational rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return to work programs
- Habilitative therapy - Therapy to maintain current functional level and prevent further deterioration
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency
- Craniosacral therapy
- Prolotherapy
- Rehabilitation services obtained from non-Health Professionals, including massage therapists
- Strength training and exercise programs
- Sensory integration therapy

## Additional Exclusions for Speech Therapy include but are not limited to

- Long standing chronic conditions where improvement is unlikely
- The expectation does not exist that the speech therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period
- Learning disabilities
- Deviant swallow or tongue thrust
- Mild and moderate developmental speech or language disorders that are self-correcting and not severe
- Vocal cord abuse resulting in life-style or employment activities such as, but not limited to cheerleading, coaching, or singing. Voice therapy is, however, covered in the presence of vocal


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cord nodules, polyps or vocal cord paralysis.

- Treatment for children who would otherwise be eligible to receive speech therapy through school or a public agency

## 8.18 Durable Medical Equipment

Durable Medical Equipment (DME) must be:

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

### Coverage

Rental or purchase of Durable Medical Equipment is covered when Medically Necessary and is limited to the basic equipment. Any special features that are considered Medically Necessary must be Preauthorized by BCN to be covered. Items are payable when received from an In-Network DME Participating Provider or a Participating facility upon discharge.

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

| Durable Medical Equipment Cost Sharing<br>Must be authorized and obtained from a BCN approved Provider |
| --- |
| 20% Coinsurance<br>Applies toward In-Network Out-of-Pocket Maximum |

**NOTE:** The following items are covered in full when Preauthorized and obtained from a DME Participating Provider as mandated by the Affordable Care Act Preventive services:

- Breast pump and associated supplies needed to support breastfeeding (See Preventive and Early Diagnosis section)
- Blood pressure monitor when a Member has elevated blood pressure reading regardless of hypertension diagnosis

### Limitations and Exclusions

### Limitations include but are not limited to:

- The equipment must be prescribed by your physician or other provider, determined to be Medically Necessary and it must be Preauthorized by BCN.
- The equipment must be considered Durable Medical Equipment under your Coverage, and must be appropriate for home use.


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- Obtained from a BCN-approved supplier
- The equipment is the property of BCN or the DME provider. When it is no longer Medically Necessary, you may be required to return it to the supplier.
- Replacement of Durable Medical Equipment is covered only when necessary due to a change in your medical condition, to accommodate body growth, body change or normal wear.

### 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 bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds, breast pumps, etc.)
- Physician's equipment (such as stethoscopes)
- Disposable supplies (such as sheets, bags, elastic stockings)
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats and treadmills)
- Self-help devices that are not primarily medical items (such as sauna baths, elevators and ramps, special telephone or communication devices)
- Equipment that is experimental or for research (see Section 9)
- Needles and syringes for purposes other than the treatment of diabetes
- Repair or replacement due to loss or damage
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers
- Any late fees or purchase fees if the rental equipment is not returned within the stipulated period of time

## 8.19 Diabetic Supplies and Equipment

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

Diabetic Supplies and Equipment must be:

- Medically Necessary
- Prescribed by your physician
- Obtained from BCN Participating Provider

### Coverage

- Blood glucose monitor


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- 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 use of an insulin pump
- Diabetic shoes and inserts

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

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

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

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

| Diabetic Supplies and Equipment Cost Sharing<br>Must be authorized and obtained from a BCN approved Provider |
|---|
| 20% Coinsurance<br>Applies toward In-Network Out-of-Pocket Maximum |

### *Exclusions include but are not limited to*

- Replacement due to loss, theft or damage that can be repaired
- Deluxe equipment unless Medically Necessary for the Member

  **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
- Alcohol and gauze pads
- Insulin and other medications
- Services and supplies whose primary purpose is the convenience of the Member or caregivers

## *8.20 Prosthetics and Orthotics*
### *Definitions*

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

- **External Prosthetic Devices:** Devices such as an artificial leg, artificial arm; including the initial set of prescription lenses for replacement of an organic lens of the eye following Medically


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Necessary eye surgery (e.g., cataract surgery) are considered External devices.

- **Internal Implantable Prosthetic Devices**: Devices surgically attached or implanted during an authorized 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.

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

### *Coverage*

In-Network and Out-of-Network Benefits for Prosthetics and Orthotics are covered only for the basic Orthotic and Prosthetic appliance and any Medically Necessary special features prescribed by the treating physician, Preauthorized by BCN and obtained from a Participating Provider or Participating facility upon discharge.

Coverage includes but is not limited to:

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

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

For specific coverage information and to locate a Participating Provider, please call Customer Service at the number provided on your ID card.

| Orthotics and Prosthetics Cost Sharing<br>Must be authorized and obtained from a BCN approved Provider |
|---|
| 20% Coinsurance<br>Applies toward In-Network 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 and it must be Preauthorized by BCN
- Coverage is limited to basic items
- Any special features that are considered Medically Necessary must be Preauthorized by BCN
- You must obtain the item from a BCN-approved supplier


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- Your physician, Provider or Participating facility upon discharge must prescribe the item

### *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
- Deluxe items unless Medically Necessary for the Member and Preauthorized by BCN
- Dental appliances, including bite splints
- Eyeglasses or contact lenses (except after lens surgery as described above)
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, wigs and hairpieces or hair transplants
- Over-the-counter arch supports, foot orthotics
- Shoe inserts that are not attached to a leg brace
- Devices that are experimental and research in nature
- Hearing Aids including bone anchored hearing aids
- Duplicate appliances and devices

## *8.21 Organ and Tissue Transplants*

Organ or body tissue transplant and all related services are covered. The following conditions must be met.

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

**NOTE**: For a Preauthorized transplant, we also cover the necessary Hospital, surgical, laboratory and x-ray Services for a non-Member donor, unless the non-Member donor has Coverage for such Services.

### *Donor Coverage*

**Donor Coverage for a BCN Recipient**

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

**Donor Coverage for a non-BCN Recipient**

- Member donor Cost Sharing may apply when Preauthorized if the recipient's health plan does not cover Member donor charges.

Cost Sharing does apply if the recipient's coverage does not cover the BCN donor charges.


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| Organ and Tissue Transplant Cost Sharing |
|---|
| In-Network and Out-of-Network |
| ✓ Covered in full after In-Network Deductible<br>✓ Must be performed at a BCN-approved transplant facility<br>✓ Applies toward In-Network Out-of-Pocket Maximum |

### Exclusions from In-Network and Out-of-Network Benefits 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 includes:

- 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
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Health Service under this Certificate of Coverage.
- Disease, accidental injury, burns and/or severe inflammation including but not limited to the following procedures:
  - Blepharoplasty of upper lids
  - Panniculectomy
  - Rhinoplasty
  - Septorhinoplasty
- Reduction mammoplasty (breast reduction surgery) for females
- Male mastectomy for treatment of gynecomastia

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

| Reconstructive Surgery Cost Sharing | |
|---|---|
| In-Network | Out-of-Network |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |


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## 8.23 Oral Surgery

Oral surgery and X-rays listed below are covered only when Preauthorized by BCN for:

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

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

  Hospital services are covered in conjunction with oral surgery when it is Medically Necessary for the oral surgery to be performed in a Hospital setting. Your Inpatient Hospital benefit will then apply.

| Oral Surgery Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Applicable Cost Share will apply based on site of care<br>✓ Applies toward In-Network Out-of-Pocket Maximum | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible of all fees associated with Facility, professional and related Services<br>✓ Applies to Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

### 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

### Definition

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.


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### Coverage

Medical services and treatment for TMJ listed below are covered when they are Medically Necessary and Preauthorized by BCN:

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

| TMJ Treatment Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

### Exclusions include but are not limited to

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

## 8.25 Orthognathic Surgery

### Definition

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

### Coverage

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

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

| Orthognathic Surgery Cost Sharing | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible |

| | |
|---|---|
| | ✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

### Exclusions include but are not limited to

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

## 8.26 Weight Reduction Procedures

Weight reduction procedures and surgery for the treatment of morbid obesity are covered when Medically Necessary based on BCN's medical criteria and established guidelines related to the procedure. Your provider must approve the service and notify BCN prior to the procedure taking place.

| Weight Reduction Surgery Cost Sharing | |
|---|---|
| In-Network | Out-of-Network |
| 10% Coinsurance after In-Network Deductible of all fees associated with Facility, professional and related Services for all weight reduction procedures<br>✓ Applies toward In-Network Out-of-Pocket Maximum | Not covered |

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

### A) Prescription Drugs Received while you are an Inpatient

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

### B) Cancer Drug Therapy

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

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

- The drug is ordered by a physician for the treatment of cancer


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- 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. The treatment is Medically Necessary and Preauthorized by BCN

**Cancer Drug Therapy Cost Sharing**

| Cancer Drug Therapy | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

| Cost of Administration | |
|---|---|
| **In-Network** | **Out-of-Network** |
| Covered in full after In-Network Deductible | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |

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

### C) Injectable and Infusible 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 select Drugs be obtained through a BCN approved designated supplier. . BCN will manage the treatment setting for injectable and infusible drug services and may direct you to a select location approved by BCN for the administration of the drug.


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

### Cost Sharing

| In-Network Benefits | Out-of-Network Benefits |
|---|---|
| 20% Coinsurance of the Approved Amount after In-Network Deductible<br><br>✓ Applies toward In-Network Out-of-Pocket Maximum | 20% Coinsurance of the Approved Amount after Out-of-Network Deductible<br><br>✓ Applies toward Out-of-Network Out-of-Pocket Maximum<br>✓ Applies toward Annual Coinsurance Maximum |
| **Note:** Injectable Drugs related to services with 50% Coinsurance will apply 50% Coinsurance of the Approved Amount after Deductible to those injectables. | |

### Exclusions include but are not limited to

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

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

## D) Cellular and Gene Therapy

### Definitions

**Cellular and Gene Therapies** – Products that involve the use of human cells or genetic modification to treat disease. The products that BCN considers to be Cellular and Gene Therapies are listed at: bcbsm.com/cellgenetherapy

**Accelerated Approval Pathway** - An FDA process that allows for earlier approval of certain drugs, including Cellular and Gene Therapies that have not yet demonstrated actual clinical benefit(s).

**Primary Endpoint** – The main outcome(s) the trial is designated to evaluate.


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### Coverage

We cover the following Cellular and Gene Therapies:

- For cancer indications

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

- For non-cancer indications that have been proven to be effective, as determined by BCN. BCN considers a Cellular and Gene Therapy to be effective to treat a condition if the following are true:
  - The drug has full FDA approval that was not obtained under the FDA's Accelerated Approval Pathway; and
  - The drug met all of its Primary Endpoint(s) in its pivotal trials; or
  - If confirmatory trials were required, the drug met its Primary Endpoint(s) in its confirmatory trial(s)

### Exclusions include but are not limited to:

- Cellular and Gene therapies for non-cancer indications that have not been proven effective as determined by BCN

### E) Outpatient Prescription Drugs

We do not cover Outpatient prescription drugs and supplies unless you have a BCN Prescription Drug Rider attached to this Certificate of Coverage. (See Section 9).

## 8.28 Clinical Trials

### Definition

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

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

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

- **Phase I:** Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients.
- **Phase II:** The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety.
- **Phase III:** If a treatment has shown to be effective in Phase II, it is subjected to additional


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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.

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

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

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

**Routine Patient Costs** means all covered items and services related to an approved clinical trial as defined under this Certificate of Coverage or any associated Riders that would be covered even if the Member is not enrolled in an Approved Clinical Trial.

## Coverage

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

- BCN considers the Experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The treatment is covered under your Certificate of Coverage and associated Riders when it is provided as conventional treatment.
- The Services related to the Experimental treatment are covered under this Certificate of Coverage and associated Riders when they are related to conventional treatment.

The Experimental treatment and related Services are provided during BCN-approved **clinical trial** (check with your provider to determine whether a Clinical Trial is approved by BCN).

**NOTE:** This Certificate of Coverage 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.


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### 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
- Routine patient costs for Phase I Clinical Trials whose primary purpose is not for therapeutic intent (e.g., prolongation of life, shrinkage of tumor, or improved quality of life, even in absence of cure or dramatic improvement of a condition)
- Administrative costs related to Experimental treatment or for research management
- Coverage for Services not otherwise covered under this Certificate of Coverage
- 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
- Use of transition technologies as a routine service in an Approved Clinical Trial such as Cellular and Gene Therapies that have not been FDA approved for those indications.

## 8.29 Autism Spectrum Disorders

### Definitions

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

**Approved Autism Evaluation Center (AAEC)** is an academic or Hospital-based, interdisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). An interdisciplinary evaluation such as that available at an AAEC is necessary to obtain Preauthorization for ABA.

**Autism Spectrum Disorders (ASD)** means a developmental disability caused by differences in the brain. Autism Spectrum Disorder is characterized by impaired social function, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests. The treatment of ASD may be behavior modification.

**Autism Spectrum Disorder Services** are Services that require a prior authorization for assessment, reassessment, and supervision of applied behavior analysis (ABA), line therapy, skills training, and caregiver training.

**Evaluation** must include a review of the Member's clinical history and examination of the Member. An evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment,


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assessment by an occupational or physical therapist and lead screening as needed.

**Line Therapy** means tutoring or other activities performed one-on-one with the person diagnosed with ASD.

## *Benefits*

Services for the diagnosis and treatment of ASD are covered when provided by a licensed provider and Preauthorized by BCN.

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 including:
  - Occupational therapy, speech therapy and physical therapy
  - Autism Spectrum Disorder Services (including ABA) when performed by a licensed behavior analyst or other providers acting within their scope of practice
  - Outpatient mental health therapy
  - Genetic testing
  - Nutritional therapy
- Services and treatment must be Medically Necessary, Preauthorized and deemed safe and effective by BCN.

## *Coverage*

ABA for Line Therapy services are subject to the In-Network and Out-of-Network outpatient behaviorial health Cost Share as defined in this Certificate. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Behavioral Health Services are subject to the In-Network or Out-of-Network behavioral health Cost Share as defined in this Certificate and any applicable Riders. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Outpatient Therapy Services are subject to the In-Network or Out-of-Network Specialist office visit Cost Sharing as defined in this Certificate and any applicable Riders. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Services performed pursuant to treat ASD will not apply toward Benefit Maximums in your Coverage including, but not limited to, visit or treatment limits imposed on speech therapy, physical therapy, or occupational therapy.

## *Benefit Limitations*

Coverage is available subject to the following requirements:

- **Preauthorization** – In-network and out-of-network Services 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. Once the initial

Preauthorization expires, a request for continued services will be authorized contingent on the Member demonstrating meaningful improvement and therapeutic progress.

- **Providers** - All services to treat ASD must be performed by a BCN approved provider.
- **Required Evaluation for ABA** – In order to receive Preauthorization, the Member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist. Other Preauthorization requirements may also apply. this interdisciplinary evaluation can be performed at an approved AAEC.

### *Exclusions*

- Any treatment that is not specifically covered in the Autism Spectrum Disorders section 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
- Treatment for conditions not covered under BCN medical policy

## *8.30 Gender Affirming Services*

### *Definitions*

**Gender Dysphoria**

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

**Gender Affirming Services**

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

### *Coverage*

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

### *Cost Sharing*

Your Inpatient and Outpatient Benefit Cost Sharing applies including office consultations as defined in this Certificate of Coverage or a Riders attached to this Certificate.

### *Exclusions include but are not limited to*

- Experimental or investigational treatment
- Reversal of transgender surgical procedures

- Gender Affirming Services that are considered cosmetic and not medically necessary such as:
  - Abdominoplasty
  - Blepharoplasty
  - Brow lift
  - Calf implants
  - Cheek/malar implants
  - Chin/nose implants
  - Collagen injections


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- Drugs for hair loss or growth
- Forehead lift
- Hair removal (exception: electrolysis)
- Hair transplantation
- Injectable dermal filler (i.e., Sculptra, Radiesse)
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Otoplasty
- 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.


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# Section 9: Exclusions and Limitations

This section lists the exclusions and limitations of this Certificate of Coverage. Please refer to a specific service within this Certificate of Coverage for additional exclusions and limitations.

## 9.1 Unauthorized Services

Except for Emergency care, select health, medical and hospital Services listed in this Certificate of Coverage 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 BCN ID card or visit https://www.bcbsm.com/priorauth.

## 9.2 Facility Admission Prior to Effective Date

If you must be admitted to a hospital, skilled nursing or residential Substance Use Disorder/psychiatric Facility **before** your effective date of Coverage, Coverage for the inpatient or Facility care will begin on the effective date of coverage **only if**:

- You have no continuing coverage under any other health benefits contract, program or insurance
- You had no previous coverage.

Advise the Facility of your change in coverage and request them to notify BCN of your Facility admission. This will assist BCN in managing your care. Failure to obtain the necessary authorization may result in a denial of benefits.

## 9.3 Services That Are Not Medically Necessary

Services that are not Medically Necessary are not covered unless specified in this Certificate of Coverage. 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 Certificate of Coverage
- Office visits, exams, treatments, tests and reports for any of the following:
  - Employment
  - Licenses
  - Insurance
  - Travel (only immunizations for purposes of travel or immigration *are* 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,


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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, See Section 8 Home Infusion Therapy Services)
- 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
- Experimental or investigational procedures, treatments, drugs or devices
- Psychoanalysis and psychotherapy that is not intended or likely to produce meaningful improvement
- 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. These centers and programs are not considered residential treatment facilities.
- 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 Coverage (i.e., are not medically necessary) such as treatment of or programs for sex offenders or


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perpetrators of sexual or physical violence

- Inpatient hospital stays, when Acute Care as an inpatient is not necessitated by the Member's condition when safe and adequate care can be received as an outpatient or in a less intensified medical setting
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs 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
    -
- Programs associated with disorders of consciousness for individuals in any of the following states of consciousness including, but not limited to, coma, cognitive motor disassociation, vegetative/unresponsive wakefulness or minimally conscious state using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation

## 9.5 Cosmetic Surgery

Cosmetic surgery is surgery done primarily to improve appearance or self-esteem but 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 or breast augmentation) or any of the related services, such as pre-or post-surgical care, follow-up care or reversal or revision of the surgery.

## 9.6 Prescription Drugs

You are not covered for any outpatient prescription drugs, over-the-counter drugs or products or any medicines incidental to outpatient care except for chemotherapy and cancer drug therapy under this Certificate of 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

There is no Coverage for Custodial Care, that is, care that is primarily for the maintenance of the Member's basic needs for food, shelter and clothing. This means that 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

Personal or comfort items, such as telephones or television are not covered. (See also Sections 8.18 for Durable Medical Equipment exclusions)

## 9.10 Court Related Services

- There is no coverage for court order 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 when services are Medically Necessary and meet the requirements 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.

## 9.11 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

The following maternity services are not covered:

- All services related to surrogate parenting arrangements, including, but not limited to, maternity and obstetrical care for non-member surrogate parents
- Services and supplies provided by a lay-midwife for home births
- Lamaze, parenting or other similar classes

## 9.12 Dental Services

There is no Coverage for dental services including services and procedures to diagnose or treat dental disease, dental prostheses, restoration or replacement of missing tooth/teeth, orthodontic care, X-rays, or anesthesia for dental procedures even if related to a medical condition or treatment except as specifically stated in Section 8.


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## 9.13 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 Certificate of Coverage;
- 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).

## 9.14 Alternate Services

Any Alternative Service (a treatment not traditionally being used in standard Western medicine and is not widely taught in medical schools) such as acupuncture, hypnosis, biofeedback, herbal treatments, massage therapy, therapeutic touch, aroma-therapy, light therapy, naturopathic medicine (herbs and plants), homeopathy, and traditional Chinese medicine is not covered.

## 9.15 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
- Visual training or visual therapy for learning disabilities such as dyslexia
- Dilation

## 9.16 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


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effectiveness or adjustments to the hearing aid


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**We Speak Your Language**

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

ܙܘܗܪܐ: ܐܢ ܐܗܬܘܢ ܟܡ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܚܠܡܬܘܬ̈ܐ ܕܗܝܪܢܘܬܐ ܕܠܫܢܐ ܒܕ ܗܘܝܐ ܦܬܝܚܐ ܩܠܘܒܝܟܘܢ ܕܠܐ ܐܓܪܐ. ܐܦ ܚܠܡܬܘܬ̈ܐ ܘܗܝܪܢܘܬܐ ܠܣܒܝܚܐ ܠܢܘܚܠܬܐ ܕܝܗܒܬܐ ܕܡܘܕܥܢܘܬܐ ܒܦܘܪܡܐ ܕܡܨܝܬܘܢ ܠܡܛܝܐ ܦܬܝܚܐ ܕܠܐ ܐܓܪܐ. ܡܚܒܪܘܢ ܥܠ ܡܢܝܢܐ 877-469-2583 TTY: 711 ܐܘ ܡܡܠܠܘܢ ܥܡ ܡܫܡܫܢܘܬܘܢ.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다.

877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

**Discrimination is against the law**

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711.

Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 888-605-6461, TTY: 711
Fax: 866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/