

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.

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

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

Blue Care Network (BCN) is a Michigan health maintenance organization in which you are enrolled.

Calendar Year is 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. Your Coinsurance is not altered by an audit, adjustment or recovery. The Coinsurance applies to the Out-of-Pocket Maximum.

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

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.

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

Covered Health Services are those Medically Necessary services, drugs or supplies identified as payable and provided in accordance with the terms of the Coverage and described in the BCN Certificate of Coverage.

Custodial Care is services that:

- Are not health related services, such as helping the patient with activities of daily living or meeting personal needs. Such care includes help walking, getting in and out of bed, bathing, cooking, cleaning, dressing and taking medicine.
- Are health related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Custodial Care is not a covered benefit.

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

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

- The use or prescription of a drug or device intended as a contraceptive;
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death; or

- Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy

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

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

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

General Provisions describes the rules of your health care Coverage.

Group is Michigan State University (MSU).

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

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

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.

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

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

Medical Episode is an acute incidence of illness or symptoms which is distinct from the patient's usual state of health, and has a defined beginning and course over a period of time. It may be related to an illness but is distinctly separate. (Example: A Member may have Chronic arthritis of the knee but may have an acute flare-up which makes the Member unable to walk at all. The acute flare-up would have a distinct beginning and would run a distinct length of time, finally reverting to the Chronic state.)

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

- Consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and also considered effective for the member's illness, injury or disease;
- Not primarily for the convenience of the member or health care provider;

- Not regarded as experimental by BCN;
- In accordance with BCN Utilization Management Criteria for Mental Health and Substance Use Disorders.

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

Mental Health Provider is a psychiatrist, licensed consulting psychologist, social worker, hospital or other Facility duly licensed and qualified to provide mental health service under the law or jurisdiction in which treatment is received.

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. Services provided by a Non-Participating Provider are subject to applicable Deductible, Copayment, and/or Coinsurance. **Unless the specific service is authorized as required under this Certificate of Coverage, a Non-Participating Provider may bill you for services rendered and you will be responsible for the entire bill.**

Observation Care consists of clinically appropriate services that include testing and/or treatment, assessment and reassessment provided before a decision can be made whether you will require further services, or may be safely discharged from the hospital setting.

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 are paid at a lower level than In-Network Benefits.

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.

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

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.

Preauthorized Service is medical service as described in this document and authorized or approved by BCN prior to obtaining the care or service.

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

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

- Doctor of Medicine
- Doctor of Osteopathic Medicine
- Doctor of Podiatric Medicine
- Certified Nurse Midwife
- Board Certified Behavior Analyst
- Physician Assistant
- Licensed Psychologist
- Doctor of Chiropractic

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

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

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

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

Skilled Care means services that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists, and speech pathologists, and/or must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the Member and to achieve the medically desired result; and
- Are ordered by the attending physician; and
- Are Medically Necessary according to generally accepted medical standards.

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

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

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

injury, or the onset of Acute or severe symptoms.

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

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CHAPTER 1 - GENERAL PROVISIONS

Section 1: Eligibility

1.1 Eligibility

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.
- **Change of Status:** You agree to notify Group Health Plan within 30 days of any change in eligibility status of you or any family dependents. When you are no longer eligible for Coverage, you are responsible for payment for any services or benefits unless the services are covered under other health benefit plan or insurance.
- If you are admitted to a Hospital or Skilled Nursing Facility prior to the effective date of this 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.

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 in order to administer Section 2. Failure to provide requested information, including information about other Coverage, may result in denial of claims.

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

- Benefits under Coverage are coordinated. That is, services and treatment for any automobile-related injury that are paid, payable or required to be provided under any automobile or no-fault automobile policy will not be paid. Coverage does not provide for "double-dipping" whereby you would recover payment for the same services from both BCN and the automobile or no-fault carrier.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers' compensation program will not be paid under Coverage.
- If any such services are paid or provided by BCN, BCN has the right to seek reimbursement on behalf of the Group Health Plan from the other program, insurer or Member who has received reimbursement.
- BCN authorization requirements must always be followed for auto or work-related injuries for them to be paid under Coverage.

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 Employer's 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.

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
- ◆ 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.

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

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"). No PCP referral is required for a Minor to receive pediatric services from the Participating pediatrician.

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

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

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

disenroll from Coverage. (See Section 5)

3.4 Refusal to Accept Treatment

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

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

3.5 Complaint and Grievance Procedure

If you have a complaint or grievance regarding any aspect of the services received that is not resolved to your satisfaction, you must follow the formal grievance procedure. You have two years from the date of discovery of a problem to file a grievance or appeal a decision of BCN. There are no fees or costs.

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

Appeals and Grievance Unit – Mail Code C248
Blue Care Network
P. O. Box 284
Southfield, MI 48086-5043
Fax 866-522-7345

Step One

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

Step Two: Review and decision by a BCN Grievance Panel

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

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

Expedited review

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

or someone acting on your behalf can initiate an expedited review by calling the Customer Service number on the back of your card or faxing BCN at 866-522-7345

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

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

3.6 Additional Member Responsibilities

You have the responsibility to:

- Read the Member Handbook, 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, BCN or BCN requests. You warrant 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.

If your card is lost or stolen, report it to customer service immediately.

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 and/or Coinsurance. If, however, circumstances require that you pay a provider, BCN will reimburse you for those Covered Health Services if you provide written proof of the payment within 12 months of the date of service. Additional information regarding the process for submitting a claim for reimbursement and the Reimbursement Form are included in the Member Handbook.

NOTE: Claims submitted more than 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.

5.2 Termination for Nonpayment

Nonpayment by the Group

- 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.

Nonpayment of Member Cost Sharing

- 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; or
- 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

Termination

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

Rescission

If you commit fraud that in any way affects your Coverage or make an intentional misrepresentation of a material fact to obtain, maintain or that otherwise affects your Coverage, BCN will consider you in breach of contract and, upon 30 days written advance notice, your membership may be Rescinded. 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 cbasm.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; and
- 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

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

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

7.6 Blue Care Network (BCN)

BCN may adopt reasonable policies, procedures, rules and interpretations to administer this Certificate of Coverage.

7.7 Litigation

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

7.8 Reliance on Verbal Communications and Waiver by Agents

Verbal verification of your eligibility for Coverage or availability of benefits is not a guarantee of

payment of claims. All claims are subject to a review of the diagnosis reported, Medical Necessity verification, and the availability of Coverage at the time the claim is processed, as well as to the conditions, limitations, exclusions, maximums, Copayments, Coinsurance and/or Deductible under Coverage.

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

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

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

7.9 Amendments

- Coverage is subject to amendment, modification or termination in accordance with the terms of the Group Health Plan.
- Such changes must be made in accordance with the terms of the contract between MSU, Group Health Plan and BCN or by mutual agreement between the MSU, Group Health Plan and BCN.

7.10 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:

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

7.11 Obtaining Additional Information

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

- The current provider network in your Service Area;
- The professional credentials of the health care providers who are Participating Providers, including Participating Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain;
- The names of Participating hospitals where individual Participating physicians have privileges for treatment;

- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider; and
- Information about the financial relationships between BCN and a Participating Provider

NOTE: Some of this information is also available on the BCN website at bcbsm.com.

7.12 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 Amendments to this Document. BCN's final adverse decisions regarding claims processing and grievances are subject to your right to appeal.

7.13 Out of Area Services

Services under this Certificate of Coverage are covered only in the state of Michigan except for emergency or BCN authorized services. Covered services received outside of Michigan will be administered through BlueCard, a Blue Cross® Blue Shield® Association program.

Definitions

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

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

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

The amount is the lesser of:

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

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

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

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

How Services are Paid

If you receive Covered Health Services in another state from a BlueCard Participating Provider, the Host Plan will pay the provider the amount required under its contract with the provider less any Deductible, Coinsurance and Copayment required under your Certificate of Coverage or Amendments. After the Host Plan pays the provider, BCN reimburses the Host Plan the amount required under the

BlueCard Program as provided for in the Designated Payment Level, described above.

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

What You Must Pay

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

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

Exclusions and Limitations

BlueCard does not apply if:

- The services are not a benefit under this Certificate of Coverage.
- The vendor or provider who provides the services has a contract with BCN for those services.

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.
- Services provided in accordance with the terms of this Certificate of Coverage are Covered Health 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 and/or Coinsurance for many of the Benefits listed. If you receive a Service that we do not cover, you will be required to pay for that Service.
- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to a review of the diagnosis reported, verification of Medical Necessity, the availability of Benefits at the time the claim is processed, as well as the conditions, limitations, exclusions, maximums, Coinsurance, Copayments and Deductible under your Certificate of Coverage and Riders.
- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.
- If a deluxe item or equipment 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 list of Services that require Preauthorization, contact Customer Service at the number provided on the back of your BCN ID card.
- You can find information about other Benefits as listed below, in the Member Handbook or at bcbsm.com
 - Disease management
 - Prevention
 - Wellness
 - Care management services

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

You may choose to receive either In-Network or Out-of-Network Benefits at any time when they are needed.

You may obtain Covered Health Services directly from a Participating Provider allowing you to receive In-Network Benefits, or you can choose to receive Covered Health Care Services from a Non-Participating Provider allowing you to receive Out-of-Network Benefits.

You must select a BCN Primary Care Physician to provide or coordinate the Covered Health Services you receive. You are responsible for determining whether a provider is a Participating Provider before obtaining services. Unless otherwise specified in this Certificate of Coverage, Benefits will be paid based on the status of the provider as of the day the services are received.

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

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.
- Emergency health services
- Urgent care center services
- Provided outside of Michigan utilizing the BlueCard Program (See Section 7.13 Out of Area Services)

Out-of-Network Benefits are generally paid at a lower rate than In-Network Benefits or may be excluded from Coverage. Out-of-Network Benefits are payable for Covered Health Services that are:

- Provided within the State of Michigan by a Non-Participating Physician, other Non-Participating provider or at a Non-Participating Facility
- Provided outside of Michigan without utilizing the BlueCard Program (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
\$100 per Member per calendar year	\$500 per Member per calendar year
\$200 per contract per calendar Year	\$1,000 per contract per calendar year
✓ Applies toward the Out-of-Pocket Maximum	✓ 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.

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	20% and 50% of the Out-of-Network Approved Amount after Out-of-Network Deductible for select services
✓ Applies toward 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 Amendments 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 \$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.

Out-of-Network Annual Coinsurance Maximum

Covered Services provided Out-of-Network apply toward the Annual Coinsurance Maximum. Once you 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 \$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 Professional (Physician) Services (Other Than Mental Health and Substance Use Disorder)

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

Office Visit Cost Sharing	
In-Network	Out-of-Network
\$20 Copayment per visit ✓ Applies to Out-of-Pocket Maximum	Primary Care Physician - Not applicable Consulting specialist care other than preventive services – 20% Coinsurance of the Approved Amount after Out-of-Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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

Maternity Care Cost Sharing	
In-Network	Out-of-Network
Covered in full See Preventive and Early Detection Services section	Prenatal and post-natal care – 20% Coinsurance of the Approved Amount after Out-of-Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

- 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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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

Allergy Care Cost Sharing	
In-Network	Out-of-Network
Covered in full ✓ Office visit Copayment may apply per Member per visit	20% Coinsurance of the Approved Amount after Out of Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

- 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 combined visits per Member per Calendar Year. For example, a spinal manipulation performed by a Chiropractor will reduce the number of spinal manipulations available from an Osteopathic Physician.

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

Chiropractic Services and Osteopathic Manipulative Therapy Cost Sharing	
In-Network	Out-of-Network
\$20 Copayment for each office visit	✓ Not covered

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

Physician Requirements

The Continuity of Care provisions apply only when 1) your physician notifies BCN of his or her agreement to accept the BCN Approved Amount as payment in full for the services provided 2) continues to meet BCN's quality standards and 3) agrees to adhere to the BCN medical and quality management policies and procedures.

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

Medical Conditions and Coverage Time Limits

- **Pregnancy Related:** If you are in your second or third trimester of pregnancy at the time of the treating physician's disaffiliation, services provided by your physician may continue through post-partum care (typically six weeks) for Covered Services directly related to your pregnancy.
- **Terminal Illness:** If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the BCN contract end, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.
- **Life-threatening condition:** If you have a life-threatening disease or condition for which death is likely if the course of treatment is interrupted. Coverage for Services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first.
- **Other Medical Conditions:** For Chronic (on-going) and Acute medical conditions (a disease or condition requiring complex on-going care such as chemotherapy, radiation therapy, surgical follow-up visits) when a course of treatment began prior to the treating physician's disaffiliation, Coverage for Services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first. The treating physician or health care provider must attest that your condition would worsen or interfere with anticipated outcomes if your care were

discontinued. Your Participating Primary Care Physician must coordinate all other Services in order for them to be Covered Services.

Coverage

- If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the “Physician Requirements” listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid, your Participating Primary Care Physician must provide or coordinate all such services.

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 following conditions and only for the time periods described below:

Coverage Time Limits and Qualification Criteria

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

Coverage

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

NOTE: You will be responsible for payment for any charges of a Non-Participating Provider if the above criteria are not met.

8.5 Preventive and Early Detection Services

We cover the following preventive services and early detection services as defined by the federal Patient Protections and Affordable Care Act (PPACA) when provided or coordinated by your Primary Care Physician. All other requirements of Coverage, such as required referrals or Preauthorizations apply.

- a) **Health assessments, health screenings and adult physical examinations** at intervals set in relation to your age, sex and medical history. Health screenings include but are not limited to:

- Obesity 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

- Gynecological (well-woman) examinations including routine pap smear and mammography screening*
- Screening for sexually transmitted diseases; HIV counseling and screening
- Contraceptive counseling and methods; office administered contraceptive devices and appliances such as intrauterine devices (IUDs); implantable and injected drugs such as Depo-Provera; and diaphragms including measurement, fittings, removal, administration; and management of side effects
- Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling
- Breast pump and associated supplies needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. Convenience items such as storage containers, bags, bottles and nipples are not covered. (See Durable Medical Equipment section for limitations and exclusions)
- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening
- Screening for gestational diabetes
- Bone density screening
- Genetic counseling and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes
- Female sterilization services
- Screening and counseling for interpersonal and domestic violence

In-Network Benefits	Out-of-Network Benefits
Covered in full	<p>Not Covered</p> <p>*Mammography screening is covered: 20% Coinsurance of the Approved Amount after Out-of-Network Deductible; may require Preauthorization</p> <ul style="list-style-type: none"> ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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.

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

In-Network Benefits	Out-of-Network Benefits
Covered in full	<p>Not Covered</p> <p>*Routine colonoscopy is covered: 20% Coinsurance of the Approved Amount after Out-of-Network Deductible; may require Preauthorization</p> <p>✓ Applies toward Annual Coinsurance Maximum</p> <p>✓ Balance Billed charges</p>

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 Amendments, the applicable Amendment 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.
- 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: For a detailed list of Preventive and Early Detection Services, please visit bcbsm.com or contact Customer Service at the number provided on the back of your ID card.

8.6 Inpatient Hospital Services

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

- Room and board, general nursing services and special diets
- Operating and other surgical treatment rooms, delivery room and special care units
- Anesthesia, laboratory, radiology and pathology services

- Chemotherapy, inhalation therapy and dialysis
- Physical, speech and occupational therapy
- Other inpatient services and supplies necessary for the treatment of the Member
- Maternity care and all related services

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

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

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

- Newborn care

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

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

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

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

Inpatient Hospital 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 <ul style="list-style-type: none"> ✓ Applies toward Annual Coinsurance Maximum ✓ Balanced Billed charges

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

8.7 Outpatient Services

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

- Surgery
- Injectables (except as excluded in Section 9)
- Chemotherapy and radiation therapy
- Dialysis
- Diagnostic tests and x-rays

Outpatient Services Cost Sharing 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 <ul style="list-style-type: none"> ✓ Applies toward Annual Coinsurance Maximum ✓ Balanced Billed charges

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.

8.8 Emergency and Urgent Care Definitions

- **Accidental Injury** - a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health. Broken bones and cuts, allergic reactions, frostbite, sunstroke, swallowing poison, overdose of medication and inhalation of smoke, carbon monoxide or fumes are considered accidental injuries.
- **Emergency Services** - services to treat Medical Emergency conditions as described below.
- **Medical Emergency** - the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Routine care for minor medical problems such as headaches, colds, slight fever, back pain or follow-up care is not considered to be a medical

emergency. A “medical emergency” is not a condition caused by an “accidental injury”.

- **Stabilization** - the point at which there is reasonable probability that no material deterioration of a condition is likely to result from or occur during your transfer.
- **Urgent Care Services** – services that appear to be required in order to prevent serious deterioration to your health resulting from an unexpected illness or injury that could be expected to worsen if not treated within 24 hours. Examples include flu, strep throat, or other infections, foreign material in the eye, sprain or pain following a fall and a cut, sore or burn that does not heal.

Coverage

Emergency Services are covered up to the point of Stabilization when they are Medically Necessary and needed either 1) for immediate treatment of a condition that is a Medical Emergency as described above or 2) if the Primary Care Physician directs you to go to an emergency care Facility.

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

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

Emergency Services and Urgent Care Copayment	
In-Network	Out-of-Network
<ul style="list-style-type: none"> • \$250 for Emergency Services provided in a hospital emergency room • \$25 for Emergency Services in an Urgent Care Center 	<ul style="list-style-type: none"> • \$250 for Emergency Services provided in a hospital emergency room • \$25 for Emergency Services in an Urgent Care Center

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 Section 8.6.

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

Follow-up care in an Emergency Care Center or Urgent Care Center, such as removal of stitches and dressings, is covered.

Emergency Services at a Non-Participating Hospital

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

Stabilization.

Out-of-Area Coverage

You are covered when traveling outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above. (See Sections 7 and 9 for additional information.)

We will pay the greater of the median in-network rate, the usual, customary and reasonable rate or the Medicare rate. You are responsible for any Cost Sharing.

8.9 Ambulance

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

The following ambulance services are covered.

Air ambulance

- When transport is ordered by the attending physician and the following conditions are met:
 - The use of an air ambulance is Medically Necessary.
 - No other means of transport is available, or the Member's condition requires transport by air rather than ground ambulance.
 - An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.
 - The Member is transported to the nearest facility capable of treating the Member's condition. The facility must be:
 - ✓ The nearest facility, or
 - ✓ Another appropriate facility within a reasonable distance of the nearest available facility.
- BCN will determine whether a facility is appropriate and what a reasonable distance is.

Emergency ground ambulance services when:

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

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

Ambulance Cost Sharing	
In-Network	Out-of-Network
20% Coinsurance after the In-Network Deductible ✓ Applies to In-Network Out-of-Pocket Maximum	20% Coinsurance after the In-Network Deductible ✓ Applies to In-Network Out-of-Pocket Maximum

Exclusions include but are not limited to

- Transportation and/or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services provided as part of a response to an accident or emergency situation, like accident clean-up or 911 costs are not a covered benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Ambulance services provided by an emergency responder that does not provide on-site treatment and transportation are not covered. The on-site treatment is covered regardless if transportation is provided.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.

8.10 Reproductive Care and Family Planning Services

This benefit includes:

- Infertility
- Sterilization
- Termination of Pregnancy
- Genetic Testing

a) Infertility

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. ✓ Applies to 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. ✓ Does not apply to Annual Coinsurance Maximum ✓ Balance Billed charges

Exclusions include but are not limited to:

- Harvesting
- Storage or manipulation of eggs and sperm
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- In-vitro fertilization procedures, such as GIFT (Gamete Intrafallopian Transfer) or ZIFT (Zygote Intrafallopian Transfer), and all related services
- Artificial insemination (except for treatment of infertility)
- All services related to surrogate parenting arrangements including, but not limited to, maternity and obstetrical care for non-member surrogate parents
- Prescription drugs

b) Sterilization

Coverage includes inpatient; outpatient and office based adult sterilization services.

Female Sterilization Cost Sharing	
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

Male Sterilization 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 for males and females

c) Elective Abortion

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

Elective Abortion 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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

d) **Genetic Testing**

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

Genetic Testing Cost Sharing	
In-Network	Out-of-Network
\$20 Copayment for each office visit	20% Coinsurance of the Approved Amount after Out of Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

Exclusion includes but is not limited to: Genetic testing and counseling for non-members

8.11 Skilled Nursing Facility Services

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

Skilled Nursing Facility Cost Sharing	
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 Annual Coinsurance Maximum ✓ Balance Billed charges
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)

8.12 Home Health Care Services

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

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency

- Intermittent physical, speech or occupational therapy
- Hospice Care
- Other health care services approved by BCN when they are performed in the Member's home

Home Care Services are covered when they are Medically Necessary.

Home Health Care Services Cost Sharing	
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 Annual Coinsurance Maximum ✓ Balance Billed charges
Limited to 60 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

- Housekeeping services
- Custodial Care (See Section 9)

8.13 Hospice Care

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

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

Hospice Care includes the following:

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

Hospice Care Cost Sharing	
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 Annual Coinsurance Maximum ✓ Balance Billed charges

Exclusions include but are not limited to

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

8.14 Home Infusion Therapy Services

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

Food Supplements

Supplemental feedings administered *via tube*:

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

Supplemental feedings administered *via an IV*:

This type of nutrition therapy is also known as **parenteral nutrition**. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

8.15 Mental Health Care

Treatment for Mental Health illnesses must be Preauthorized as Medically Necessary except in an emergency. (See Section 8.8)

- Coverage is limited to solution-focused treatment and crisis intervention.
- Only treatments that are expected to result in measurable, substantial and functional improvement are covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary to restore reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic illnesses that are Medically Necessary or to those Outpatient services needed to prevent an Acute episode of a Chronic illness
- Medical services required during a period of mental health admission must be authorized separately by BCN.

Definitions

- **Assertive Community Treatment** is a service-delivery model that provides intensive, locally based treatment to people with serious and persistent mental illness.
- **Inpatient Mental Health Service** is the service provided during the time you are admitted to a BCN approved acute care Facility that provides continuous 24-hour nursing care.
- **Intensive Outpatient Mental Health** services are acute care services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 2 days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.
- **Outpatient Mental Health** services include individual, conjoint, family or group psychotherapy and crisis intervention.
- **Partial Hospitalization Mental Health** is a comprehensive, acute care program that consists of a minimum of 6 hours per day, 5 days a week. Treatment may include, but is not limited to counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of inpatient psychiatric hospitalization.
- **Residential Mental Health Treatment** is treatment that takes place in a licensed mental health facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential treatment is:
 - Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
 - A structured environment that will allow the individual to reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the Member's usual living environment; and
 - Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program"), however, the benefit design will be the same as your medical inpatient benefit

when Preauthorized by BCN.

Coverage

Mental health care is covered in a variety of settings. You may be treated in an Inpatient or in an Outpatient setting. To obtain services you can call BCN Behavioral Health Management available 24 hours a day, 7 days a week at the number provided on your ID card.

Inpatient Mental Health/Residential 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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

Outpatient Mental Health/Intensive Outpatient Mental Health Cost Sharing	
In-Network	Out-of-Network
Covered in full	20% Coinsurance of the Approved Amount after Out-of-Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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

See Section 9 for Exclusions and Limitations.

8.16 Substance Use Disorder/Chemical Dependency Services

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

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

- Coverage is limited to solution focused treatment and crisis intervention. Solution focused treatment includes both individual and group sessions.
- Only treatments that are expected to result in measurable, substantial and functional improvement are covered.
- Coverage is limited to the least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- Coverage is limited to Acute Illnesses or Acute episodes of Chronic Illness or to those outpatient services that are Medically Necessary in order to prevent an Acute episode of a Chronic Illness.
- Medical inpatient services required during a period of Substance Use Disorder admission must

be Preauthorized separately by BCN.

Definitions

- **Detoxification (Detox)** means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detox can occur in an Inpatient, Outpatient or Residential setting.
- **Domiciliary Partial** refers to partial hospitalization combined with an unsupervised overnight stay (residential) component.
- **Intensive Outpatient Substance Use Disorder Treatment** means day treatment that is provided on an outpatient basis. Intensive Outpatient Substance Treatment consists of a minimum of 3 hours per day, 2 days per week and may include, but is not necessarily limited to, individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.
- **Intermediate Care** refers to Substance Use Disorder services that have a residential (overnight) component. Intermediate Care includes Detox, domiciliary partial and residential (including Inpatient and rehabilitation) services.
- **Outpatient Substance Use Disorder Treatment** means outpatient visits (e.g., individual, conjoint, family or group therapy) for a Member who is dependent on and/or abusing alcohol or drugs or both. The visit may include counseling, Detox, medical testing, diagnostic evaluation and referral for other services.
- **Partial Hospitalization/Domiciliary Partial** is a comprehensive, acute care program that consists of a minimum of 6 hours per day, 5 days a week. Partial Hospitalization treatment may include, but is not necessarily limited to, counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.
- **Residential Substance Use Disorder Treatment** means Acute care services provided in a structured and secure (24 hour) per day setting to a Member who is ambulatory and does not require medical hospitalization. Residential Substance Use Disorder Treatment may include 24-hour professional supervision and may include counseling, Detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Residential Substance Use Disorder treatment is sometimes referred to as Inpatient Substance Use Disorder treatment or Rehabilitation.

Coverage

Substance Use Disorder services including counseling, medical testing, diagnostic evaluation and Detox are covered in a variety of settings. To obtain services you can call BCN Behavioral Health Management available 24 hours a day, 7 days a week at the number provided your ID card.

Detox/Residential/Intermediate Care/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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

Outpatient/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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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/or Rehabilitation is treatment for recovery from surgery, disease or injury which consists of the following:

- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic spinal manipulation and Osteopathic manipulative treatment
- Medical rehabilitation - includes but not limited to cardiac and pulmonary rehabilitation

Short-term physical therapy and medical rehabilitation services including speech therapy are covered when they are Preauthorized by BCN as Medically Necessary for a condition which is deemed subject to significant physical improvement within 60 days.

Outpatient Rehabilitation Cost Sharing	
In-Network	Out-of-Network
\$20 Copayment for each visit	20% Coinsurance of the Approved Amount after Out-of-Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges
Limited to 60 combined visits per calendar year	

Benefit Limitation: 60 combined visits per calendar year. The limit is combined for In-Network and Out-of-Network services. NOTE: The maximum number of Outpatient Rehabilitation visits received In-Network and Out-of-Network is combined. For example, use of a visit In-Network will reduce the visits available Out-of-Network.

General exclusions include but are not limited to

- Cognitive therapy and retraining
- Vocational rehabilitation
- 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

Speech therapy exclusions include but are not limited to

- Chronic conditions or congenital speech abnormalities
- Learning disabilities
- Deviant swallow or tongue thrust
- Mild and moderate developmental speech or language disorders
- Vocal cord abuse resulting in life-style activities or employment activities; such as but not limited to cheerleading, coaching, singing, etc.
- Treatment for children who would otherwise be eligible to receive speech therapy through school or a public agency

8.18 Durable Medical Equipment

Definitions

Durable Medical Equipment (DME) is equipment that must be used primarily for medical purposes. It must be intended for repeated use and be useful primarily as a result of illness, injury or congenital defect.

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 must be obtained from a BCN approved Provider.

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, 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.

<p>Durable Medical Equipment Cost Sharing Must be authorized and obtained from a BCN approved Provider</p>
<p>20% Coinsurance Applies to Out-of-Pocket Maximum</p>

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.
- Obtained from a BCN-approved supplier
- The equipment is the property of BCN or the supplier. 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 blood pressure cuffs and 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 as listed below are covered for the prevention and treatment of clinical diabetes when Medically Necessary, prescribed by your physician and obtained from BCN approved provider.

- Blood glucose monitor
- 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; and
- Diabetic shoes and inserts

Diabetic supplies and equipment are limited to basic equipment. Any special features that are considered Medically Necessary must be Preauthorized by BCN. Replacement of diabetic equipment is covered only when Medically Necessary.

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 Must be authorized and obtained from a BCN approved Provider
20% Coinsurance Applies to Out-of-Pocket Maximum

Exclusions include but are not limited to

- Replacement due to loss or damage
- Deluxe equipment unless Medically Necessary for the Member and required so the Member can operate the equipment
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 Orthotics and Prosthetics

Definitions

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

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

Prosthetic devices can be either:

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

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 and Preauthorized by BCN.

Coverage is included for breast prostheses required following a Medically Necessary mastectomy. Repair, replacement, fitting and adjustments are covered when made necessary by normal wear and tear

or by body growth or change.

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).

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 Must be authorized and obtained from a BCN approved Provider
20% Coinsurance Applies to 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.
- Your physician or Provider 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

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

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.

Organ and Tissue Transplant Cost Sharing	
In-Network	Out-of-Network
Covered in full after In-Network Deductible	Not covered

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 may include:

- Correction of a birth defect that affects function
- Breast reconstructive surgery following a Medically Necessary mastectomy
This may include nipple reconstruction, surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment for physical complications resulting from the mastectomy, including lymphedema
- Reduction mammoplasty (breast reduction surgery) for females
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Health Service under this Certificate of Coverage, disease, accidental injury, burns and/or severe inflammation
- Male mastectomy for treatment of gynecomastia

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

Reconstructive Surgery Cost Sharing	
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 Annual Coinsurance Maximum ✓ Balance Billed charges

8.23 Oral Surgery

Oral surgery and X-rays 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
- Dental anesthesia for oral surgery in an outpatient setting when Medically Necessary and Preauthorized by BCN
- Medically Necessary surgery for removing tumors and cysts within the mouth

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

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

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

Oral Surgery Cost Sharing	
In-Network	Out-of-Network
\$20 Copayment for each office visit	20% Coinsurance of the Approved Amount after Out-of-Network Deductible ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

Exclusions include but are not limited to

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

(See Section 9 for additional exclusions.)

8.24 Temporomandibular Joint Syndrome (TMJ) Treatment

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

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

Covered services include:

- 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 ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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

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

Coverage

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

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

Orthognathic Surgery Cost Sharing	
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 Annual Coinsurance Maximum ✓ Balance Billed charges

Exclusion includes but is not limited to

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

8.26 Weight Reduction Procedures

Weight reduction procedures and surgery for the treatment of morbid obesity are covered when all of the following conditions are met:

- The medical criteria and guidelines established by BCN
- The procedure is Preauthorized by BCN as Medically Necessary.

Weight Reduction Surgery Cost Sharing	
In-Network	Out-of-Network
10% Coinsurance after In-Network Deductible for all weight reduction procedures, including related facility and professional services ✓ Applies to 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.

Prescription Drugs Received while you are an Inpatient

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

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;
- 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; and
- 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 <ul style="list-style-type: none"> ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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 <ul style="list-style-type: none"> ✓ Applies toward Annual Coinsurance Maximum ✓ Balance Billed charges

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

Injectable Drugs

The following drugs are covered as medical benefits.

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

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

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

Exclusions include but are not limited to

- Drugs not approved by the FDA
- 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 Amendment.

Outpatient Prescription Drugs

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

8.28 Clinical Trial

Definition

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

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

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

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

effects associated with long-term use. Phase IV studies are required by the FDA when there are any remaining unanswered questions about a drug, device or treatment.

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

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

Qualified Individual means a Member eligible for Coverage under this Certificate 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 he/she meets the trial's protocol.

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

- The investigational item, device or Service itself;
- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the member; or
- A Service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Coverage

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

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

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

NOTE: This 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.

Limitations and exclusions include but are not limited to

- The Experimental or Investigational item, device or Service itself;

- Experimental treatment or Services related to Experimental treatment , except as explained under “Coverage” above;
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Administrative costs related to Experimental treatment or for research management; or
- Coverage for Services not otherwise covered under this Certificate 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

8.29 Autism Spectrum Disorders

Definitions

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

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

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

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

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

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

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

Benefits

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

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

Coverage

ABA treatment is available to children through the age of 19. This limitation does not apply to:

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

ABA for Line Therapy services is subject to the In-Network Primary Care Physician office visit Copay and Out of Network Cost Sharing as defined in the Certificate of Coverage. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Behavioral health services included in the Treatment Plan are subject to the In-Network Primary Care Physician office visit Copay and Out-of-Network Cost Sharing as defined in this Certificate of Coverage. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Outpatient therapy services included in the Treatment Plan are subject to the specialist Cost Sharing as defined in this Certificate of Coverage. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Effective 5-1-18, Services performed pursuant to the recommended Treatment Plan will not apply toward Benefit Maximums in your Coverage including, but not limited to, visit or treatment limits imposed on speech-language pathology, physical therapy, or occupational therapy.

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

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

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Limitations

Coverage is available subject to the following requirements:

- **Preauthorization** - Services performed under the recommended Treatment Plan must be approved for payment during BCN's Preauthorization Process. If Preauthorization is not obtained, rendered services will not be covered and the Member may be held responsible for payment for those services.
- **Prior Notification** - BCN must receive prior notification of the evaluation and diagnostic assessment of the Member.
- **Providers** - All services to treat ASD must be performed by a BCN approved provider.
- **Required Diagnosis for ABA** – In order to receive Preauthorization, the Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, Participating developmental pediatrician or other professional as agreed upon by the BCN AAEC. Other Preauthorization requirements may also apply. The requirement to be evaluated and diagnosed by the BCN AAEC does not exist for other services related to ASD.
- **Termination at age 19**- Benefits are limited to children up to and including the age of 19. This age limitation does not apply to outpatient mental health services (excluding applied behavioral analyses services) and services used to diagnose ASD. Benefits for ASD terminate at the end of the calendar year in which the child turns 19.
- **Treatment Plan** - Services must be included in a Treatment Plan recommended by a BCN AAEC that evaluated and diagnosed the Member's condition.

- Measurable improvement in the Member’s condition must be expected from the recommended Treatment Plan. Once treatment begins, the plan will be subject to periodic assessment by BCN nurse or case manager.

Exclusions

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

8.30 Gender Dysphoria Treatment

Definition

Gender Dysphoria

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

Gender Reassignment Services

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

Coverage

We cover Services for the treatment of Gender Dysphoria when determined to be Medically Necessary, Preauthorized by BCN and performed by 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 an Amendment attached to this Plan.

Exclusions include but are not limited to

- Experimental or investigational treatment
- Reversal of transgender surgical procedures

Gender reassignment services that are considered cosmetic and not medically necessary such as:

- Abdominoplasty
- Blepharoplasty
- Breast enhancements
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Chondrolaryngoplasty (Adams Apple reduction)
- Collagen injections

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

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

Section 9: Exclusions and Limitations

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

9.1 *Unauthorized Services*

Select health, medical and hospital services listed in this Certificate of Coverage are covered **only** if they are Preauthorized by BCN.

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; or
- 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, 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

9.5 Cosmetic Surgery

Cosmetic surgery is surgery done primarily to improve appearance and/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. However, a prescription drug Amendment that allows coverage be issued, providing prescription drug coverage for a flat-dollar Copay after the Deductible.

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 Mental Health/Substance Use Disorder

Coverage does not include the following services:

- Care provided by Non-Participating facilities except for emergency admissions to the point of stabilization
- Psychoanalysis and open-ended psychotherapy
- Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living (ADL) or to keep from continuing unhealthy activities
- Transitional living centers such as three-quarter house or half-way house, therapeutic, boarding schools, domiciliary foster care and milieu therapies such as wilderness programs, other supportive housing, and group homes
- Maintenance treatments for caffeine and opiate addiction
- Treatment of Chronic illnesses is limited to:
 - Treatment that is Medically Necessary to prevent an Acute episode of Chronic illness
 - Treatment of Acute exacerbation of Chronic illness (any level of care, subject to other exclusions).
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment
- Treatment programs that have predetermined or fixed lengths of care
- Court ordered examinations, tests, reports or treatments that do not meet requirements for Mental Health or Substance Use coverage
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider
- Gambling addiction issues
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes

9.11 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 as specified in Sections 8.
- There is no coverage for services related to your commission of a crime or participation in an illegal activity.
- There is no coverage for services rendered while you are in the custody of law enforcement.

9.12 Elective Procedures

The following Elective Procedures are not covered:

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

9.13 Dental Services

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.

9.14 Services Covered Through Other Programs

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

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or 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).

9.15 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.

9.16 Vision Services

The following Vision Services or items are not covered:

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

9.17 Hearing Services

The following Hearing Services or items are not covered:

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

