U-M Grad Care
Member Handbook
with your Benefit Document and Amendments
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February 21, 2014

Dear Sample University of Mi Sg 0002 Cl 0005,

We’re pleased you’re a member of U-M Grad Care, a plan that’s committed to helping you achieve your wellness goals.

This book has been personalized for you as a guide to your benefits. It explains how your plan works. It also describes the resources we offer to help you stay healthy, get better if you’re ill or injured and improve your quality of life while living with an illness. We suggest that you keep it for your reference.

After you’ve looked through this book, please take a moment to tell us about your enrollment experience and how this book helped. A postage-paid card is attached to the back page for your convenience in responding.

If you have any questions, please call us. Our automated telephone response system is available 24/7 to answer many of your questions. Customer Service representatives are also available to assist you, and we’ve listed other important numbers below for your information.

Thank you for your membership.

Sincerely,

Kevin James Klobucar
President and CEO

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**Important phone numbers**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>1-800-482-5982</td>
</tr>
<tr>
<td>BlueHealthConnection®</td>
<td>1-800-637-2972</td>
</tr>
<tr>
<td>Care while you travel (BlueCard®)</td>
<td>1-800-810-BLUE (2583)</td>
</tr>
<tr>
<td>Chronic condition management nurse line</td>
<td>1-800-392-4247</td>
</tr>
<tr>
<td>Diabetic supplies (J&amp;B Medical Supply Company)</td>
<td>1-888-896-6233</td>
</tr>
<tr>
<td>Durable medical equipment (Northwood)</td>
<td>1-800-667-8496</td>
</tr>
<tr>
<td>Laboratory (Joint Venture Hospital Laboratories)</td>
<td>1-800-445-4979</td>
</tr>
<tr>
<td>Quality Management</td>
<td>248-455-3471</td>
</tr>
<tr>
<td>Quit the Nic</td>
<td>1-800-811-1764</td>
</tr>
</tbody>
</table>

**Call:** Customer Service (8 a.m. to 5:30 p.m. Monday through Friday) 1-800-658-8878
TTY users 711

Our automated telephone response system is available 24/7 to answer many of your questions.
After regular business hours, please leave a message.
A representative will return your call within two business days.

We offer translation services for non-English speakers. Over 140 languages are available.

**Write:** Member Inquiry, Blue Care Network, P.O. Box 68767, Grand Rapids, MI 49516-8767
Include your name, address, day and evening telephone numbers and your enrollee ID as shown on your BCN identification card.
Hello, Sample University of Mi Sg 0002 Cl 0005!
Welcome to U-M Grad Care.

Ready to get the most from your

1  Pick a primary care physician for yourself and everyone on your contract. All health services must be handled through your PCP. Care you arrange on your own may not be covered.

Need to choose a PCP? Visit bcbsm.com/find-a-doctor or call Customer Service at the number at the bottom of the page. Keep in mind that if our records show “None Selected” for your PCP, we’ll assign one.

2  Schedule your next appointment today. Get to know your PCP by making an appointment for your covered wellness visit, or if you need to get or renew a prescription. Why not make an appointment while you’re thinking about it?

3  Register for your online account. Our website, bcbsm.com, is your 24/7 gateway to member services and tools. If you haven’t signed up yet, take a moment now. All you need is your member number, which you can find on your ID card.

In this handbook, you’ll find:

Your customized Benefit Summary  Page 03
Read your plan’s key features and benefits, including cost-sharing requirements, coverage limitations and exceptions.

Guidelines to Good Health  Page 22
See the exams, tests and vaccines that BCN covers and how often you should have them to stay on top of your health.

Details about your travel coverage  Page 18
BCN covers you at home and when you travel. Carry your member ID card wherever you go, and be sure to follow your plan’s coverage rules.
YOUR PLAN DETAILS

Your **U-M Grad Care** plan is provided by BCN Service Company in partnership with **Blue Care Network** – the only Michigan HMO backed by the reputation and security of Blue Cross Blue Shield of Michigan.

**Know your networks.**
Your **U-M Grad Care** network has two tiers:

**U-M Grad Care Provider Network 1** gives you access to all U-M providers. You’ll pay less when you see U-M Network 1 doctors and specialists.

**U-M Grad Care Provider Network 2** offers expanded access to all BCN Service Company providers in Michigan, provided you get a referral from a U-M Network 1 provider.

**Note:** Certain services require prior authorization from BCN. BCN doesn’t cover care from doctors who have not contracted with us.

WHAT WE PAY

Because BCN contracts with doctors, hospitals and health care professionals across Michigan, we pay them directly when you get covered services. That means no paperwork or forms for you to fill out, and no hassle.

Healthy hints

**Not feeling well? Call your PCP.** Your PCP’s role is to take care of you when you’re ill, and to help you stay healthy. When you need to see a specialist, your PCP will give you a referral. Under our Women’s Choice program, women can see a participating OB-GYN without a referral.

**Getting care? Show your card.** Your member ID card is your key to PCP, specialist, urgent and emergency care, hospital care, and all other health care covered by your plan. Your member ID card is sent separately – if you don’t have it yet, watch your mail.

**Have other coverage? Let us know.** Because more than one insurer may be responsible for paying your claims, it’s important to tell us if you have health coverage in addition to your BCN plan. Call Customer Service or fill out the online *Coordination of Benefits Form*.

**Want a different PCP? Choose one online.** Visit [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor) to select a different doctor for yourself or any member of your family. For your children, you can select a pediatrician. Or, you can choose one general practitioner or family doctor for all members in your family.

Don’t forget to tell us – if you change doctors and don’t let us know, you may not be covered.

**What you pay for services**

**Copayment or copay** A fixed amount you pay for services at the time you get them – for example, $25 for an office visit. Your Benefit Summary lists your copayments for different services.

**Coinsurance** Your share of the cost of health care services after you’ve met your deductible, always a percentage. For example, your health plan pays 80% while you pay 20%.

**Deductible** The amount you pay for health care services, such as a hospital stay, before your plan starts to pay. For example, if you have a $1,000 deductible, we start paying for covered health care services after you’ve spent $1,000 out of pocket.

**Out-of-pocket maximum** The most you may have to pay for covered health care services during a plan year, including your deductible, copayments and coinsurance.
About your benefit summary

This is an easy-to-read description of some of the most frequently used benefits. This summary provides only a general overview of your benefits. It is not a contract or an official description of coverage. Additional limitations and exclusions may apply to covered services. An official description of your benefits is contained in your Benefit Document and accompanying amendments. To view your most current Benefit Document and amendments, please log in as a member at bcbsm.com, or call Customer Service and ask for a free-of-charge paper copy of the document.

In addition to this summary, you may also have access to a Summary of Benefits and Coverage, customized for you as required by the Affordable Care Act. This summary is available from your employer.

What you pay

Payment amounts are based on the Blue Care Network approved amount, less any applicable cost sharing (deductible, coinsurance or copayment) required by the plan. Your cost share may apply to the out-of-pocket maximum, depending on your plan. Once you meet your plan’s annual out-of-pocket maximum, your plan will pay for any additional covered health care services in full. You will not have any additional out-of-pocket costs for the remainder of the year.

Your primary care physician provides your care or manages it through a referral process. Only your primary care physician can refer you to specialist care. If your primary care physician doesn’t refer you, you are responsible for the charges. Certain services must also be authorized by BCN.

Your plan features a two-tiered provider network. You spend the least when you receive care from Network 1 providers.

### Annual Deductible and Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>This plan has no deductible.</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum - deductibles, copays and coinsurance amounts for covered services apply to the out-of-pocket maximum</td>
<td>$6,350 per individual, $12,700 per family out-of-pocket maximum/Levels 1, 2 and 3 combined. Excludes prescription drug cost sharing.</td>
</tr>
</tbody>
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### Physician Office Services

<table>
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<tr>
<th>Service</th>
<th>Description</th>
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</thead>
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<tr>
<td>Primary Care Physician Visits</td>
<td>$20 copay for PCP office visits for non-preventive care. Preventive care and screenings including annual health exams, well-woman exams, newborn and well-child assessments are covered in full in Level 1, Level 2 and Level 3. See BCBSM.com for complete list of preventive services.</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>Level 1 - $20 copay for specialist office visits. Level 2 Registered member - $20 copay for specialist office visits. Preventive services and screenings as recommended by the U.S. Preventive Services Task Force including office administered contraceptive devices and appliances are covered in full in Level 1, Level 2 and Level 3. Note: Services provided by a chiropractor are not covered.</td>
</tr>
</tbody>
</table>
## Benefit Summary

### Physician Office Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1 Description</th>
<th>Level 2 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>Pre and postnatal maternity visits are covered in full.</td>
<td>Pre and postnatal maternity visits are covered in full. See Hospital Care below for facility charges.</td>
</tr>
<tr>
<td>Allergy Office Visit</td>
<td>$20 copay required for allergy office visits.</td>
<td>$20 copay for allergy office visits.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Pediatric and adult immunizations as recommended by the advisory committee on immunization practices are covered in full.</td>
<td></td>
</tr>
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### Emergency Services

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<tr>
<th>Service</th>
<th>Level 1 Description</th>
<th>Level 2 Description</th>
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</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>$75 copay for emergency room services; copay waived if admitted to the hospital.</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$20 copay for emergency services in an urgent care center.</td>
<td></td>
</tr>
<tr>
<td>Emergent Ambulance Services</td>
<td>No copay required for emergency ambulance transport when other transportation would endanger members life.</td>
<td></td>
</tr>
<tr>
<td>Non-Emergent Ambulance Services</td>
<td>No copay required for non emergency ground transport when other transportation would endanger members life.</td>
<td></td>
</tr>
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### Diagnostic and Therapeutic Services

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<th>Level 1 Description</th>
<th>Level 2 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and Pathology Services</td>
<td>No copay required for laboratory and pathology services.</td>
<td>No copay required for laboratory and pathology services.</td>
</tr>
<tr>
<td>X-Ray</td>
<td>X-ray and radiology services are covered in full. Office visit copay may apply.</td>
<td>X-ray and radiology services are covered in full. Office visit copay may apply. Mammograms, bone density screenings and other preventive screenings are covered in full in Level 1, Level 2 and Level 3.</td>
</tr>
<tr>
<td>Outpatient Facility Visits/Diagnostic Services</td>
<td>Outpatient facility diagnostic services are covered in full.</td>
<td>Outpatient diagnostic services are covered in full. Note: Mammograms, bone density screening and other preventive screenings are covered in full in Level 1, Level 2 and Level 3.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Radiation therapy is covered in full.</td>
<td>Radiation therapy is covered in full.</td>
</tr>
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<td>Chemotherapy</td>
<td>Chemotherapy is covered in full.</td>
<td>Chemotherapy is covered in full.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Dialysis treatment is covered in full.</td>
<td>Dialysis treatment is covered in full.</td>
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### Benefit Summary

#### Hospital Care

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<th>Level 1 Details</th>
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<tr>
<td>Inpatient Hospital Admission</td>
<td>Inpatient hospital admission is covered in full.</td>
<td>Registered member - Inpatient hospital admission is covered in full.</td>
</tr>
<tr>
<td></td>
<td>Note: All services for transgender surgery require preauthorization.</td>
<td></td>
</tr>
<tr>
<td>Newborn Care</td>
<td>Level 1, Level 2 and Level 3 - Newborn care in an inpatient setting is covered in full.</td>
<td></td>
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#### Alternatives to Hospital Care

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<th>Level 1 Details</th>
<th>Level 2 Details</th>
</tr>
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<tr>
<td>Skilled Nursing Facility</td>
<td>Services in a skilled nursing facility are covered in full.</td>
<td>Registered member - Services in a skilled nursing facility are covered in full.</td>
</tr>
<tr>
<td>Skilled Nursing Facility Days</td>
<td>45 days skilled nursing care per calendar year in a skilled nursing facility.</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>Inpatient or outpatient hospice are covered in full services.</td>
<td>Hospice is not a covered benefit.</td>
</tr>
<tr>
<td>Home Care Visits</td>
<td>$20 copay required for home care visits, requires BCN authorization.</td>
<td>Registered member - $20 copay for home care visit; requires BCN authorization.</td>
</tr>
</tbody>
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#### Surgical Services

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<th>Level 1 Details</th>
<th>Level 2 Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery Facility</td>
<td>Services in an outpatient surgery facility are covered in full when authorized by BCN.</td>
<td>Registered member - Services in an outpatient surgery facility are covered in full.</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>$20 copay for second surgical opinion.</td>
<td>Registered member - $20 copay for second surgical opinion.</td>
</tr>
<tr>
<td>Surgical Assistant</td>
<td>Services performed by a surgical assistant are covered in full.</td>
<td>Registered member - services performed by a surgical assistant are covered in full.</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Anesthesia in an inpatient or outpatient hospital setting is covered in full.</td>
<td>Registered member - Anesthesia in an inpatient or outpatient hospital setting is covered in full.</td>
</tr>
<tr>
<td>Sterilization Procedures</td>
<td>No copay for adult sterilization; office visit copay may apply.</td>
<td>Registered member - Adult sterilization covered in full. Office visit copay may apply.</td>
</tr>
<tr>
<td>Termination Procedures</td>
<td>Elective first trimester termination; medical termination in 2nd and 3rd trimester covered in full; office visit copay may apply.</td>
<td>Registered member - Elective first trimester termination; medical termination in 2nd and 3rd trimester covered in full; office visit copay may apply.</td>
</tr>
</tbody>
</table>
## Benefit Summary

### Surgical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1</th>
<th>Level 2 Registered members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Reduction Procedures</td>
<td>$1,000 copay for weight reduction procedures when authorized by BCN as medically necessary.</td>
<td>Weight reduction procedures are not a covered benefit.</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>$10 copay per office visit for orthognathic services.</td>
<td>$20 copay per office visit for orthognathic services.</td>
</tr>
</tbody>
</table>

### Mental Health and Substance Abuse Treatment

- **Inpatient Mental Health**: Level 1 - Inpatient mental health services covered in full when preauthorized by BCN. Level 2 Registered member - No coverage for non emergent admissions.
- **Inpatient Mental Health Days**: Unlimited when medically necessary, provided by a participating provider and authorized by BCN.
- **Inpatient Mental Health Time Period**: Coordinated by Behavioral Health management.
- **Outpatient Mental Health**: Level 1 - $20 copay per outpatient mental health visit. Level 2 - $20 copay per outpatient mental health visit. Includes diagnosis and treatment for autism spectrum disorders when authorized by BCN.
- **Outpatient Mental Health Visit Limit**: Unlimited when medically necessary, provided by a participating provider and authorized by BCN.
- **Outpatient Mental Health Additional Visits**: Coordinated by Behavioral Health management.
- **Inpatient Substance Abuse**: Level 1 - Intermediate substance abuse services are covered in full. Level 2 Registered member - No coverage out of area except emergency admission.
- **Inpatient Substance Abuse Time Period**: Coordinated by Behavioral Health management.
- **Outpatient Substance abuse**: Level 1 - $20 copay per visit for outpatient substance abuse services. Level 2 Registered member $20 copay per visit.
- **Outpatient Substance Abuse Visit Limit**: Unlimited when medically necessary, provided by a participating provider and authorized by BCN.
- **Detoxification - Substance Abuse**: Level 1 - Substance abuse detoxification treatment is covered in full. Level 2 registered member - No coverage out of area except for emergency admission.

### Durable Medical Equipment, Diabetic Supplies and Prosthetics and Orthotics

- **Durable Medical Equipment**: Level 1 - No copay for durable medical equipment. Level 2 - Registered member - No copay required for durable medical equipment when obtained from a BCN contracted supplier. Breast pump to support breast feeding covered in full. Authorization required.
- **Diabetic Supplies**: Level 1 - Diabetic supplies are covered in full. Level 2 Registered members - Diabetic supplies are covered in full when obtained from a BCN contracted supplier.
### Benefit Summary

**Durable Medical Equipment, Diabetic Supplies and Prosthetics and Orthotics - Call Northwood at 1-800-667-8496.**

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1</th>
<th>Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetics</strong></td>
<td>Prosthetic appliances are covered in full.</td>
<td>Registered members - Prosthetic appliances are covered in full when obtained from a BCN contracted supplier.</td>
</tr>
<tr>
<td><strong>Orthotics</strong></td>
<td>Orthotic appliances are covered in full.</td>
<td>Registered member - Orthotic appliances are covered in full when obtained from a BCN contracted supplier.</td>
</tr>
</tbody>
</table>

#### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Level 1</th>
<th>Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Evaluation/Serum/Testing</strong></td>
<td>No copay required for allergy related services; office visit copay may apply.</td>
<td>Registered member - No copay required for allergy related services; office copay may apply.</td>
</tr>
<tr>
<td><strong>Allergy Injections</strong></td>
<td>Allergy injections are covered in full.</td>
<td>Registered member - Allergy injections are covered in full.</td>
</tr>
<tr>
<td><strong>Infertility Care (Criteria Required)</strong></td>
<td>$20 office visit copay for infertility assessment; Level 2 - Registered member - $20 office visit copay for infertility assessment.</td>
<td>In Vitro fertilization and the treatment of infertility including prescription drugs are not covered.</td>
</tr>
<tr>
<td><strong>Outpatient Physical, Occupational and Speech Therapy/Outpatient Rehabilitation</strong></td>
<td>$20 copay per visit for outpatient physical, speech and occupational therapy.</td>
<td>Registered member - $20 copay per visit for outpatient physical, speech and occupational therapy including pulmonary and cardiac rehabilitation.</td>
</tr>
<tr>
<td><strong>Outpatient Physical, Occupational and Speech Therapy/Outpatient Rehabilitation Limits</strong></td>
<td>Treatment for major diagnosis limited to 60 visits per calendar year for any combination of therapies. Minor diagnosis limited to 15 visits per calendar year for any combination of therapies.</td>
<td>Cardiac rehabilitation covered up to 36 sessions in 18 week period per medical episode.</td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorder</strong></td>
<td>$20 copay per visit for applied behavioral analysis. ABA is limited to 25 hours per week for line therapy.</td>
<td>$20 copay per visit for autism related speech, physical and occupational therapy with unlimited visits. Requires prior authorization from BCN.</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint (TMJ)</strong></td>
<td>$20 copay per office visit for TMJ services when authorized by BCN as medically necessary.</td>
<td>$20 copay per office visit for TMJ services when authorized by BCN as medically necessary.</td>
</tr>
<tr>
<td><strong>Hearing Aid and Evaluation</strong></td>
<td>LEVEL 1 - HEARING EVALUATION, AUDIOMETRIC EXAM, HEARING AID EVALUATION AND BASIC BINAURAL HEARING AIDS AVAILABLE EVERY 36 MONTHS. REPAIRS AND BATTERIES ARE NOT COVERED. OFFICE VISIT COPAY MAY APPLY. LEVEL 2 REGISTERED MEMBERS, APPLIES TO THE LIFETIME MAXIMUM OF $500,000.</td>
<td></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Vision exam covered in full; coverage is limited to one routine vision exam per calendar year.</td>
<td>Registered member covered up to $40.00 per member per calendar year.</td>
</tr>
</tbody>
</table>
Your U-M Grad Care Coverage

About your U-M Grad Care plan
Your U-M Grad Care coverage is provided through a partnership with BCN Service Company and Blue Care Network. This book explains the programs and policies that support your coverage.

Early diagnosis and treatment can keep minor problems from turning serious. Rapid treatment can help you get better when you’re ill or injured. BCN oversees care management programs that include preventive services such as physical exams, immunizations and well-child care. BCN also provides health information, risk assessment tools and special programs to help you reach your health and wellness goals.

BCN manages the medical networks that serve you, whether you’re getting preventive care or treatment. If you have a chronic illness, BCN chronic condition and case management programs can help you manage your condition and achieve the best possible quality of life.

How to get services
Carry your identification card with you at all times and show it each time you need health care. Be sure to see your primary care physician first. For care to be covered, all services have to be handled through your primary care physician. Care you seek on your own may not be covered.

Where to get services
U-M Grad Care features a two-tiered provider network.

- Provider Network 1 provides managed care with access to all U-M providers and nearly all the former M-CARE network.
- Provider Network 2 allows expanded access to the rest of the BCN Service Company providers in Michigan with a referral from a U-M Grad Care Network 1 provider.

What you pay out of pocket
When you receive medical and behavioral health covered services, you may be responsible for a deductible, a copayment and coinsurance. Your out-of-pocket costs are lowest when you receive care from Network 1 providers, and when your primary care physician provides or coordinates your care using designated Network 1 specialists. Certain services require prior authorization from BCN Service Company. Care you seek from providers who aren’t in Network 1 or 2 won’t be covered.

For more information, contact your benefits representative or Customer Service.

The doctor, hospital or other health care provider will bill us for covered services. If a network provider asks you to pay more than your copayment for covered services, please call Customer Service.

In the unlikely event that you had to pay for covered services, we’ll reimburse you for our share of the cost. Call Customer Service for the form you need to get reimbursed. Or download a copy from bcbsm.com/billform.
Your U-M Grad Care Coverage

Complete the form and send it to Member Claims, Blue Care Network, P.O. Box 68767, Grand Rapids, MI 49516-8767 with:

- An itemized bill, including diagnosis, date and type of service
- Proof of payment (a cancelled check or receipt from the provider)
- The treatment record or emergency report

Some services aren’t covered
Your plan doesn’t cover the following:

- Services obtained without a referral or BCN authorization
- Cosmetic services or supplies
- Custodial care
- Experimental or investigational treatment
- Personal convenience items
- Rest cures
- Routine examinations related to employment, insurance licensing, a court order or travel
- Acupuncture
- Self-help programs
- Services or supplies received before the effective date of coverage or after coverage has ended
- Services that could have been paid under workers’ compensation laws
- Services or supplies that could be paid by government programs
- Services that are not medically necessary

Coordination of benefits
BCN Service Company coordinates your benefits with other insurers to make sure you get maximum coverage. Coordination of benefits also helps us keep down the cost of health care.

Here are some situations where we coordinate your BCN coverage with other insurers:

- You are covered by BCN Service Company and also have health care coverage through your spouse’s employer.
- Someone in your family is covered by Medicare and has BCN Service Company coverage to pay for that portion of the charges not covered by Medicare.
- Your children are covered by your BCN Service Company contract and also have coverage through their other parent’s health care plan.
- Your spouse is employed and has coverage through his or her employer in addition to your BCN Service Company coverage.
- You were injured in an auto accident or at work, and your auto insurance or your workers compensation insurance is responsible for medical services.
If you receive a coordination of benefits questionnaire from BCN, please complete it and return it to us as quickly as possible. If we don’t receive your coordination of benefits information, we may not be able to process your claim.

For more information about coordination of benefits and for a copy of the form, visit bcbsm.com. Enter coordination of benefits in the search box in the upper right corner of the page.

Changing your records
Contact your group benefits representative to make changes to your record. Make sure you report address changes or life events within 31 days of when they happen so we can process the change and pay your claims.

These are the events you should report:

• Birth of a child
• Adoption or legal guardianship
• Marriage
• Divorce
• Death
• Name change
• New home address or telephone number
• Medicare eligibility
Manage coverage and more on bcbsm.com

Our website is a valuable resource for health information that can help you get the most from your coverage. Here’s some of what you can do:

- Complete a health assessment and develop a personal action plan with our online health coach.
- Verify eligibility for everyone on your contract.
- Order ID cards.
- View and print claim summaries.
- View your benefits.
- Change your primary care physician.
- Use our Coverage Advisor™ to compare health plans and their costs.
- View and pay your bill online. Get details at bcbsm.com/ebilling.

To access all these features, log in to your account at bcbsm.com.

Note to new members: You can log in as a member immediately after your effective date of coverage.

Complete a health assessment

Take control of your health by taking a health assessment, available from the bcbsm.com home page. (Click on Healthy Living, Getting Started, Health Assessment.) After you answer some questions about your health, you’ll receive a healthy living plan that’s created just for you.

It’s a good idea to have the following medical information on hand when you take the health assessment:

- Your blood pressure
- Your cholesterol levels (total and HDL)
- The approximate date of your last checkup
- When you had your most recent vaccinations, such as for flu and tetanus
- When you had your most recent screenings, such as a mammogram or colonoscopy

If you include this information when you fill out the questionnaire, your results will be more accurate and recommendations to you more focused. If you don’t have your medical information, write in your best guesses.

If you would like to complete a health assessment but don’t have Internet access, call us at 1-800-873-0509. Have your contract number (or enrollee ID number) and group number ready.
Your primary care physician is your health care partner — a doctor who knows your medical history and coordinates your care.

Your PCP provides checkups and monitors your health, writes prescriptions, takes care of you when you’re ill and gives referrals when you need specialist care. If you were seeing a specialist before switching to BCN coverage, your new primary care physician must reauthorize your treatment. If you have drug coverage, your new primary care physician should also check the medications you’ve been receiving to see if we cover them.

Your doctor or the doctor on call can be reached 24 hours a day, seven days a week, through an answering service. Make sure you have your doctor’s telephone number handy at all times. Post it near your home telephone, and always carry it with you.

In an emergency, always go to the nearest hospital emergency room or call 911. Tell your primary care physician about the problem within 24 hours or as soon as you can. It’s fine if another person calls on your behalf.

Choosing a primary care physician

You can choose a primary care physician who is an M.D. (medical doctor) or a D.O. (osteopathic doctor). Each person covered under your contract must select a primary care physician, but members of the same family don’t have to have the same physician. Adults may choose one doctor type for themselves and another for their children from these categories:

- **Family medicine and general practice** — These practitioners treat patients of all ages, from newborns to adults. They also provide obstetrical and gynecological care.
- **Preventive medicine** — These practitioners promote health and well-being for patients of all ages.
- **Internal medicine** — Internists are trained to identify and treat adult and geriatric medical conditions. Most of our network internists treat patients age 18 and older.
- **Internal medicine/pediatrics** — Physicians who are trained in internal medicine and pediatrics treat infants, children, adolescents and adults.
- **Pediatrics** — Pediatricians specialize in the treatment of infants, children and adolescents 18 years and younger.

Our physicians have the credentials

Your physician is required to meet our strong network affiliation standards. We screen our physicians to find out if they meet our quality requirements for professional training and medical practice. You can verify the license status of our health care providers at [www.dleg.state.mi.us/free/](http://www.dleg.state.mi.us/free/) or by calling the Michigan Department of Consumer and Industry Services at 517-241-9427.

*This website is not controlled by BCN, and BCN is not responsible for its content.*
Finding a primary care physician
To find network physicians, use our online search tool at bcbsm.com/find-a-doctor or call Customer Service.

Online or on the phone, you can:

- Locate practices by languages spoken, handicap accessibility, gender, credentials or hospital affiliations
- Find out if a doctor is accepting new patients
- Get directions to doctors, hospitals and facilities

Changing a primary care physician
Tell us when you want to change doctors, by doing one of the following:

- Log in to your account on bcbsm.com. Click on Manage my plan in the left menu; then click on Primary care physician.
- Call Customer Service.

Changes are limited to one every 30 days. When you change primary care physicians, any referrals you have in process need to be reissued by your new doctor.

Woman’s Choice
A female member can see a gynecologist or obstetrician for Pap smears, annual well-woman visits and obstetrical care without a referral. Our Woman’s Choice program allows you to visit a BCN-affiliated gynecologist, obstetrician or obstetrician/gynecologist in addition to your primary care physician.

Because your primary care physician coordinates nonroutine gynecological care, consider selecting a gynecologist who belongs to the same physician group. When your doctors practice in the same location and use the same hospital, it is easier for them to take care of you.
When you need medical care

You must have a BCN-contracted primary care physician to access your benefits. Call your primary care physician first for all your health care needs — from a routine checkup to an injury or illness (high fever, unusual pain) that needs prompt attention.

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Description</th>
<th>Time frame</th>
<th>What you need to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care</td>
<td>A health history and exam. Includes screenings and shots listed in the Guidelines to Good Health in this Member Handbook. For women, this includes your annual gynecology exam.</td>
<td>Within 30 days</td>
<td>• Call well in advance. • Bring all prescriptions and over-the-counter medications. • Always bring immunization records. • Make a list of questions to ask your doctor.</td>
</tr>
<tr>
<td>Routine primary care</td>
<td>• Conditions that are not sudden or not life threatening or symptoms that keep coming back, such as rashes and joint or muscle pain. • Conditions that need ongoing care.</td>
<td>Within 10 days</td>
<td>Call ahead to ensure prompt service. If a follow-up visit is needed, schedule it before you leave the doctor's office.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Sudden but not life-threatening conditions, such as: • Fevers greater than 101 degrees lasting for more than 24 hours • Vomiting that persists • Mild diarrhea • A new skin rash</td>
<td>Within 2 days</td>
<td>Call your primary care physician. Your physician or an on-call doctor will provide care or direct you to an urgent care center near your home. You can also locate an urgent care center near you at bcbsm.com/find-a-doctor.</td>
</tr>
<tr>
<td>Emergency care</td>
<td>A condition that causes symptoms severe enough that someone with average health knowledge would believe that immediate medical attention is needed</td>
<td>Immediately</td>
<td>• Seek help at the nearest emergency room or call 911. • Contact your primary care physician within 24 hours.</td>
</tr>
<tr>
<td>Hospital care</td>
<td>Conditions that require inpatient care</td>
<td>As needed</td>
<td>Your primary care physician will arrange the hospital care you need and direct the care of any specialists who will see you there.</td>
</tr>
</tbody>
</table>
When you need behavioral health care

Call the mental health help number on the back of your ID card 24 hours a day, seven days a week to obtain behavioral health services (substance abuse care and mental health services). A care manager will evaluate your needs and arrange for services. You do not need a referral from your primary care physician.

When you receive inpatient mental health care, it’s a good idea to continue care with an outpatient mental health professional immediately after discharge.

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Description</th>
<th>Time frame</th>
<th>What you need to do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine care</strong></td>
<td>Where no danger is detected and the member's ability to cope is not at risk.</td>
<td>Within 10 days</td>
<td>Tell the behavioral care manager of any special needs to ensure appropriate referral.</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Conditions that are not life-threatening, but face-to-face contact is necessary within a short period of time (example: severe depression)</td>
<td>Within 48 hours</td>
<td>Call the mental health help number on the back of your ID card.</td>
</tr>
<tr>
<td><strong>Emergency care for conditions that are not life-threatening</strong></td>
<td>Conditions that require rapid intervention to prevent deterioration of the patient’s state of mind, which, left untreated, could jeopardize the patient’s safety</td>
<td>Within 6 hours</td>
<td>Call the mental health help number on the back of your ID card.</td>
</tr>
</tbody>
</table>
| **Emergency care for life-threatening conditions** | A condition that requires immediate intervention to prevent death or serious harm to the patient or others | Immediately    | • Seek help at the nearest emergency room, or call 911.  
• Contact your primary care physician within 24 hours. |
| **Hospital care**                                | Conditions that require inpatient care                                       | As needed      | Your primary care physician will arrange the hospital care you need and direct the care of any specialists who will see you there. |
Your doctor coordinates specialty health care
The more complicated the health care system becomes, the more important it is to help you navigate it. Your primary care physician — in partnership with you and in coordination with BCN — will arrange the specialty health care you need, referring you to doctors in our network. Most likely, the specialist will be someone your doctor knows professionally. By managing your care, your primary care physician makes sure that you get appropriate services and that the specialty care you receive becomes part of your health portfolio.

Referrals help your doctor monitor your care
Your primary care physician manages your health care through a referral process, which begins with you and your primary care physician determining the need for specialty health care. Here are some important points to remember about referral care:

• Your primary care physician refers you to a specialist. The referral isn’t always in paper form.
• The treatment period can range from 30 days to 365 days.
• You may need special approval from BCN for certain services and for services from specialists who are not part of the BCN network.
• Your specialist can’t refer you to another specialist. Only your primary care physician can refer you to specialist care.
• If your primary care physician doesn’t refer you, you are responsible for the charges.
• Changing your primary care physician while a specialist is treating you may change your treatment authorization. Check with your new primary care physician.
• If you and your primary care physician are unable to agree about specialty care, please call Customer Service.

Out-of-network care
You must have a referral from your primary care physician before you get care from providers who are not part of our network, and BCN must authorize the care. If you receive medical care from providers who are not part of our network without an authorized referral from your primary care physician and BCN, you will be responsible for the cost of the service.
Special care for women

- **Breast reconstruction following a mastectomy**
  The Women's Health and Cancer Rights Act of 1998 includes important protection for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Our coverage complies with this legislation and includes the following:
  - Reconstruction of the breast on which the mastectomy has been performed for treatment of cancer
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and other care to alleviate physical complications of all stages of a mastectomy

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

  A physician or other health provider does not need authorization to prescribe a length of stay up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician or certified nurse midwife, in consultation with the mother, may discharge the mother or newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Pain management

We provide coverage for the comprehensive evaluation and treatment of diseases, which includes the management of symptoms such as pain that may be associated with them. We consider pain management services an integral part of a complete disease treatment plan, subject to limitations detailed in your Benefit Document and Amendments. These can be viewed online at [bcbsm.com](http://bcbsm.com) after you log in as a member.

Continuing care with a doctor

In certain situations, you may be able to continue seeing the doctor you had under your previous health plan. In order to qualify for this continuity of care, your doctor must agree to keep you as a patient and must notify you of that intent in writing. Your doctor must also agree to accept BCN’s reimbursement as payment in full and follow BCN’s quality standards, utilization review policies and procedures.

For care to continue, one of these situations must apply:

- You must be receiving care for an ongoing course of treatment, and disruption of that care would interfere with recovery (care may continue until the treatment ends).
- You are in the second or third trimester of pregnancy (care may continue through postpartum)
- You have a terminal illness (care may continue for the remainder of the member’s life).

Continuity of care may also apply when your BCN doctor is no longer part of our network.
**Access to Care**

**Carry your member ID card when you travel**

One of the many benefits of BCN Service Company is coverage that travels with you. You can receive benefits when you’re away from home — on a short trip or for an extended time through BlueCard®. This Blue Cross and Blue Shield Association program gives members access to physicians in the United States wherever a Blue plan is offered. Call your primary care physician before you travel to arrange for coordinated care and required authorizations. See the chart below for care that needs to be authorized in advance.

Learn more about the BlueCard® program, which is part of your contract, by reading the disclosure document online at [bcbsm.com/bluecarddisclosure](http://bcbsm.com/bluecarddisclosure) or call Customer Service at 1-888-288-2738 to have a copy sent to you.

### Access to Care

<table>
<thead>
<tr>
<th>If you’re traveling</th>
<th>And you need</th>
<th>Here’s what you do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Michigan where BCN is offered</strong></td>
<td><strong>EMERGENCY CARE</strong> (The symptoms are severe enough that someone with average health knowledge believes that immediate medical attention is needed.)</td>
<td>Call 911 or go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td></td>
<td><strong>URGENT CARE</strong> (The condition requires a medical evaluation within 48 hours.)</td>
<td>Call your primary care physician. To locate a participating urgent care center, call Customer Service or visit <a href="http://bcbsm.com/find-a-doctor">bcbsm.com/find-a-doctor</a>.</td>
</tr>
<tr>
<td></td>
<td><strong>NONURGENT CARE</strong></td>
<td>Call your primary care physician to coordinate services that don’t require immediate attention.</td>
</tr>
<tr>
<td><strong>In Michigan where BCN is not offered</strong></td>
<td><strong>EMERGENCY CARE</strong></td>
<td>Call 911 or go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td>(You are covered for emergency care only.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In the United States but outside Michigan</strong></td>
<td><strong>EMERGENCY CARE</strong></td>
<td>Call 911 or go to the nearest hospital emergency room.</td>
</tr>
<tr>
<td></td>
<td><strong>URGENT CARE</strong></td>
<td>Call BlueCard at 1-800-810-BLUE (2583)</td>
</tr>
<tr>
<td></td>
<td><strong>FOLLOW-UP CARE</strong> (To treat or monitor a chronic condition)</td>
<td>Call Customer Service for details about your health benefits and required authorizations.</td>
</tr>
<tr>
<td></td>
<td><strong>ROUTINE CARE</strong> (Doctor’s visit for a minor illness)</td>
<td>Call BlueCard at 1-800-810-BLUE (2583) to find a physician at your destination.</td>
</tr>
<tr>
<td></td>
<td><strong>OTHER SERVICES</strong> (Such as elective surgeries, hospitalizations, mental health or substance abuse services)</td>
<td>Call Customer Service for details about your health benefits and to determine which services require prior authorization.</td>
</tr>
<tr>
<td><strong>Outside the United States</strong></td>
<td><strong>EMERGENCY CARE</strong></td>
<td>Go to the nearest hospital emergency room. (You may be required to pay for services and then seek BCN reimbursement.)</td>
</tr>
</tbody>
</table>

Note: Before you go, call Customer Service for details about your health care benefits.
Physicians, hospitals and other providers of care that have contracted with BCN Service Company and BCN are available in the counties noted below.
Durable medical equipment
In general, durable medical equipment is only covered when appropriate for use in the member’s home. Your primary care physician determines what you need and writes a prescription for the basic equipment or appliances, as well as for any additional medically necessary items. Certain prescriptions require BCN authorization.

J&B Medical Supply Company partners with BCN to provide diabetic materials, including insulin pumps and blood glucose meters. For more information, call J&B Customer Service at 1-888-896-6233. Medical equipment for diabetic patients (such as glucose monitors and insulin pumps) are considered durable medical equipment and may be covered as part of your medical benefit.

Northwood Inc. partners with BCN to provide all other durable medical equipment for members, as well as all prosthetic and orthotic appliances. To locate the Northwood provider nearest you, please call 1-800-667-8496. Representatives are available from 8:30 a.m. to 5:30 p.m. Monday through Friday. On-call associates are available after business hours.

If you qualify only for basic services but wish to receive items considered deluxe or items that do not meet our medical necessity criteria, you may elect to pay the difference between the provider’s charge and the allowed maximum for the basic services.

Lab provider offers access across the state
Your lab work is performed by the same hospital in your community that you and your physicians use for most other services. BCN contracts with Joint Venture Hospital Laboratories to provide clinical laboratory services. This partnership offers statewide access to more than 80 hospitals and 200 service centers that provide 24-hour access and a full range of laboratory services. For information about patient service centers in your community, call 1-800-445-4979 or visit JVHL.org.*

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Our BlueHealthConnection® umbrella of care is designed to help you stay healthy, get better or live well with illness. We offer health education, disease management and case management programs, tailored to your needs and built on our partnership with members, physicians and other providers.

**Health education keeps you informed**
Knowledge is an important part of prevention because the more you know the better you can be. We keep you informed so you can stay on top of your health.

- Read our *Good Health* magazine, sent twice a year, for information about your benefits, advice on healthy self-care practices and the latest news about our medical, behavioral health and pharmacy programs.
- Sign up for our free BCN e-newsletter at [bcbsm.com/enewsletters](http://bcbsm.com/enewsletters) for articles on how to improve your health, seasonal tips and an *Ask the Coach* feature.
- Make an appointment with your doctor when you get one of our reminders to get a health checkup, screening or immunization.
- Call 1-800-637-2972 to request a free self-help guide on nutritious eating, exercise, depression, high blood pressure, stress management, losing weight, back pain, cholesterol or quitting smoking.

**Money-saving offers**
People who achieve a healthy weight and increase their activity feel better and decrease their risk of developing medical problems such as high blood pressure, diabetes and heart disease. The Blues help you stay healthy and save money at the same time.

- Healthy Blue Xtras℠ is a Blues program with special offers from companies across Michigan. Savings cover a variety of healthy goods and services from groceries and fitness gear to yoga and gym packages.
- Members can stay healthy 365 days a year by using Blue365®, a program sponsored by the Blue Cross and Blue Shield Association. Savings cover activities such as fitness, weight control, recreation and alternative medicine. Blue365 also provides helpful resources that allow you to make informed health care decisions.

For more information and for access to discounts, visit [bcbsm.com](http://bcbsm.com), and click on the **Healthy Living** menu at the top of the page.

**No more tobacco**
Because tobacco is linked to many life-threatening illnesses, we want to help you quit.
Our tobacco cessation program includes a battery of tools to help you quit. You get educational materials and ongoing telephone support to keep you motivated. Call 1-800-811-1764 to enroll. The hours are 9 a.m. to 9 p.m. Monday through Saturday.
Good health guidelines for adults

When it comes to risk and disease, men and women are not very different, according to the Centers for Disease Control. The leading causes of death for men and women in the United States are:

- Heart disease
- Cancer
- Stroke
- Lung disease (including emphysema and chronic bronchitis)

The good news is you can reduce your risk for these diseases. Together with the Centers for Disease Control, we recommend you:

- **Eat healthy, balanced meals.** Eating five or more servings of fruits and vegetables a day and less saturated fat can help improve your health and may reduce the risk of cancer and other chronic diseases.

- **Keep your weight under control.** Anyone who’s overweight has increased risks for diseases and conditions such as diabetes, heart disease and stroke.

- **Exercise.** Thirty minutes of moderate physical activity a day will keep you fit and help prevent disease. Exercise can be cutting the grass or just walking. The important thing is to get moving.

- **Don’t smoke.** Smoking increases your risk for cancer and heart disease. If you smoke, join BCN’s effective smoking cessation program by calling 1-800-811-1764.

- **Manage stress.** Stress can keep us on our toes or undermine our health. If stress is causing you to eat poorly, drink too much, smoke or neglect your health, you need to take time to be good to yourself.

- **Get routine exams and screenings** for high blood pressure, high cholesterol, diabetes, sexually transmitted diseases and cancer. When problems are found early, your chances for treatment and cure are better.

**Heart healthy tip:** Ask your doctor about aspirin use.

Use the following timetable of health actions to help prevent illness or detect conditions in their earliest stages. These guidelines are based on recommendations provided by the Michigan Quality Improvement Consortium and are updated by MQIC every two years unless new research reveals findings that affect the current recommendations.
### Good health guidelines for adults

<table>
<thead>
<tr>
<th>MEN &amp; WOMEN</th>
<th>AGE</th>
<th>HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health exam</strong> <em>(including, height and weight assessment, body mass index evaluation and obesity counseling, alcohol/drug abuse, tobacco use and injury)</em></td>
<td>18 – 49</td>
<td>Every 1 – 5 years</td>
</tr>
<tr>
<td></td>
<td>50 – 65+</td>
<td>Every 1 – 3 years</td>
</tr>
<tr>
<td><strong>Blood pressure screening</strong></td>
<td>18+</td>
<td>Every 2 years if blood pressure is ≤ 120/80. Every year if blood pressure is higher than 120 – 139/80 – 89. Screen more frequently if needed.</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>18 – 65+</td>
<td>Every 3 years with blood pressure ≥ 135/80.</td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>18 – 49</td>
<td>If at high risk, ask your doctor. Fecal occult blood test OR Sigmoidoscopy every 5 years with fecal occult blood test every 3 years OR Colonoscopy every 10 years Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>50 – 75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>76+</td>
<td></td>
</tr>
<tr>
<td><strong>Glaucoma screening</strong></td>
<td>18 – 64</td>
<td>If at high risk, ask your doctor.</td>
</tr>
<tr>
<td><strong>Osteoporosis screening</strong></td>
<td>50 – 64</td>
<td>Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td>Screen</td>
</tr>
<tr>
<td><strong>HIV screening</strong></td>
<td>18 – 64</td>
<td>One test for everyone Every year if high risk</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td></td>
</tr>
<tr>
<td><strong>MEN</strong></td>
<td>AGE</td>
<td>HOW OFTEN</td>
</tr>
<tr>
<td><strong>Cholesterol and lipid screening</strong></td>
<td>35+</td>
<td>Every 5 years; more often with risk factors</td>
</tr>
<tr>
<td><strong>Prostate cancer</strong> <em>(digital rectal exam and/or prostate-specific antigen test)</em></td>
<td>50 – 74</td>
<td>Ask your doctor.</td>
</tr>
<tr>
<td><strong>WOMEN</strong></td>
<td>AGE</td>
<td>HOW OFTEN</td>
</tr>
<tr>
<td><strong>Cholesterol and lipid screening</strong></td>
<td>20 – 45+</td>
<td>Ask your doctor.</td>
</tr>
<tr>
<td><strong>Osteoporosis screening</strong></td>
<td>50 – 64</td>
<td>Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td>Test</td>
</tr>
<tr>
<td><strong>Mammogram</strong> <em>(with or without clinical breast exam)</em></td>
<td>18 – 49</td>
<td>Ask your doctor. Every 2 years Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>50 – 74</td>
<td>Every 2 years Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>75+</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical cancer/ Pap test screening</strong></td>
<td>21 – 64</td>
<td>Every 3 years Ask your doctor.</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia screening</strong></td>
<td>Under 24</td>
<td>Every year</td>
</tr>
<tr>
<td></td>
<td>(sexually active)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25+</td>
<td>(if high risk)</td>
</tr>
<tr>
<td></td>
<td>Pregnant women</td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy (prenatal visits)</strong></td>
<td>Childbearing</td>
<td>Week 6 – 8: First visit Week 14 – 16: 1 visit Week 24 – 28: 1 visit Week 32: 1 visit Week 36: 1 visit Week 38 – 41: Every week</td>
</tr>
<tr>
<td><strong>Pregnancy (postnatal visits)</strong></td>
<td>Childbearing</td>
<td>Once 21 – 56 days after delivery</td>
</tr>
<tr>
<td><strong>IMMUNIZATIONS MEN &amp; WOMEN</strong></td>
<td>AGE</td>
<td>HOW OFTEN</td>
</tr>
<tr>
<td><strong>HPV (human papillomavirus)</strong></td>
<td>Females, 9 – 26</td>
<td>3 doses</td>
</tr>
<tr>
<td></td>
<td>Males, 9 – 26</td>
<td></td>
</tr>
<tr>
<td><strong>Tdap</strong></td>
<td>After age 12</td>
<td>1 dose</td>
</tr>
<tr>
<td><strong>Tetanus</strong></td>
<td>18 – 65+</td>
<td>Once every 10 years</td>
</tr>
<tr>
<td><strong>Flu</strong></td>
<td>18 – 65+</td>
<td>Every year</td>
</tr>
<tr>
<td><strong>MMR</strong></td>
<td>18 – 49</td>
<td>1 – 2 doses if needed</td>
</tr>
<tr>
<td><strong>Varicella</strong> <em>(chicken pox)</em></td>
<td>18 – 65+</td>
<td>2 doses if needed</td>
</tr>
<tr>
<td><strong>Hepatitis A, Hepatitis B, Meningococcal</strong></td>
<td>18 – 65+</td>
<td>If high risk</td>
</tr>
<tr>
<td><strong>Pneumococcal</strong> <em>(meningitis and pneumonia)</em></td>
<td>18 – 64</td>
<td>If high risk 1 dose. If you received a dose before age 65, and 5 or more years have passed since the first dose, get another dose at age 65.</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td></td>
</tr>
<tr>
<td><strong>Zoster</strong> <em>(shingles)</em></td>
<td>60+</td>
<td>One dose</td>
</tr>
</tbody>
</table>
Good health guidelines for children

Every child is unique, developing according to his or her own schedule.

Regular well-child visits and scheduled immunizations for childhood disease can help keep your child healthy.

The HPV vaccine, which protects against the two types of HPV that cause most (70 percent) cervical cancers, is recommended for 11- to 12-year-old girls.

Adolescents need boosters and some vaccines. For example, college freshmen who will be living in a dorm have an increased risk of developing meningococcal disease.

We’ve developed a timetable of health actions for you to follow to help prevent illness or detect conditions in children in their earliest stages. Ask your child’s doctor about what schedule is right for him or her.

**Note:** These guidelines are based on recommendations provided by the Michigan Quality Improvement Consortium and are updated by MQIC every two years unless new research reveals findings that affect the current recommendations.
## Boys & Girls

### Well-child exam
- **Parental education:** nutrition; development; injury and poison prevention; SIDS; coping skills; tobacco-use screening; secondhand smoke; height, weight and body mass index

- **0 – 24 months:** 11 visits
- **2 – 18 years:** Every year

### Neonatal and hearing screening
- **Birth (after 24 hours):** Once

### Cholesterol screening
- **2+ years:** Ask your doctor.

### Lead screening
- **Between 9 months and 18 months:** Once

### Vision screening
- **2 – 6 years:** Before starting school
- **7 – 12 years:** Every 2 years
- **13 – 21 years:** Every 3 years

### Preconception and pregnancy (prevention and counseling)
- **12+ years or earlier if sexually active:** Every year

### Flu
- **6 months – 8 years:** 2 doses first year, then every year
- **9 – 21 years:** Every year

### Hib-haemophilus
- **2 – 15 month:** Complete series

### HPV (human papillomavirus)
- **Females, 9 – 26 years:** 3 doses
- **Males, 9 – 26 years:** Ask your doctor.

### DTaP
- **2, 4, 6 months:** 1st, 2nd, 3rd dose
- **15 – 18 months:** 4th dose
- **4 – 6 years:** 5th dose

### Rotavirus
- **2 – 6 months:** Complete series

### Tdap
- **11 – 12 years:** 1 dose

### Hepatitis A
- **12 months:** 1st dose
- **18 – 24 months:** 2nd dose

### Hepatitis B
- **Birth:** 1st dose
- **1 – 2 months:** 2nd dose
- **6 – 18 months:** 3rd dose

### IPV-polio
- **2 months:** 1st dose
- **4 months:** 2nd dose
- **6 – 18 months:** 3rd dose
- **4 – 6 years:** 4th dose

### HiB-haemophilus
- **2 – 15 month:** Complete series

### Flu
- **6 months – 8 years:** 2 doses first year, then every year
- **9 – 21 years:** Every year

### MMR (measles, mumps and rubella)
- **12 – 15 months:** 1st dose
- **4 – 6 years:** 2nd dose

### Varicella (chicken pox)
- **12 – 15 months:** 1st dose
- **4 – 12 years:** 2nd dose

### Meningococcal
- **11 – 12 years:** 1 dose
- **16 – 18 years:** Booster

### Pneumococcal conjugate (pneumonia)
- **2 months:** 1st dose
- **4 months:** 2nd dose
- **6 months:** 3rd dose
- **12 – 15 months:** 4th dose
Some hospitals stand out
We’ve identified hospitals and other facilities that have consistently demonstrated expertise in delivering quality health care as Blue Distinction Centers for Specialty Care®. These centers of excellence provide quality health care in the following specialties:

- Blue Distinction Centers for Bariatric Surgery®
- Blue Distinction Centers for Cardiac Care®
- Blue Distinction Centers for Complex and Rare Cancers®
- Blue Distinction Centers for Knee and Hip Replacement®
- Blue Distinction Centers for Spine Surgery®
- Blue Distinction Centers for Transplants®

Blue Distinction Centers are part of a national program developed with the Blue Cross and Blue Shield Association and other Blue plans across the country. The Blue Distinction designation means these facilities met criteria established with recommendations from expert clinicians and leading professional organizations. Although individual outcomes may vary, the Blue Distinction designation can help members and physicians make informed decisions when selecting a quality facility for certain procedures.

Selecting a hospital with a Blue Distinction designation is not required.

For more information about these facilities, visit bcbsm.com. Click on FAQs, listed under the Help menu at the top of the page. Click Getting Care in the left column under the Browse by Topic heading.

How to live better with chronic illness
Management is your key to living with a chronic medical condition. Our BlueHealthConnection chronic condition management programs provide the information and people to help you manage your condition and achieve the best possible quality of life. We offer programs for:

- Asthma
- Cardiovascular heart disease
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure

For more information about our programs, the various tools we offer and the levels of assistance with chronic conditions, call our BlueHealthConnection nurse line at 1-800-392-4247.
When you need extra care
When you’re seriously ill or injured, we offer extra help. Our case management support includes information about treatment options, coordination of care and social work counseling. Our registered nurses work closely with you, your primary care physician and your specialist to help arrange the services needed and support you through the treatment your physician orders. Your case manager can also help you find community resources.

In addition to the conditions noted on the previous page, the following are generally monitored through case management:

- Chronic progressive disease (for example, lupus, rheumatoid arthritis and multiple sclerosis)
- Emergency room use for members who have been using the emergency room frequently
- Kidney disease
- Heart disease following a heart attack, angioplasty or coronary bypass surgery
- High-risk pregnancy for women who may expect complications during pregnancy and delivery
- Pediatric care
- Oncology
- Organ transplant
- Catastrophic condition (for example, stroke or brain injury)

For more information or to see if you qualify to enroll in one of our case management programs, please call Customer Service.

Quality management
Our quality improvement programs help doctors give appropriate care. Please call our Quality Management department at 248-455-3471 for more information about our programs and guidelines.

For health information, call BlueHealthConnection at 1-800-637-2972..

Advance directives speak for you when you cannot
Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. The legal documents that you can use to give your directions in advance in these situations are called advance directives.

Talk with your physician about your health and potential future health needs. You will also want to discuss your wishes with family and friends.

Preparing an advance directive is your choice and not a health care requirement. Whether or not you create one will not affect your health care coverage.

For information about creating an advance directive and for the forms you need to complete, visit bcbsm.com. Click on FAQs, listed under the Help menu at the top of the page. Click Other Topics in the left column under the Browse by Topic heading.
Part of the Blues family
BCN Service Company is a subsidiary of Blue Care Network. Both are independent, nonprofit affiliates of Blue Cross Blue Shield of Michigan. Both operate under licenses from the Blue Cross and Blue Shield Association that permit them to use the Blue Cross and Blue Shield names and service marks in Michigan.

BCN Service Company is governed by a three-member board of directors, each of whom also serves on the 18-member BCN board of directors that includes BCN subscribers and other private citizens, as well as representatives of large business, small business, labor, physicians, hospitals and other health care providers.

As an independent licensee of the Blue Cross and Blue Shield Association, BCN Service Company is required to furnish you with the following disclosure statements:

• The Blue Cross and Blue Shield Association licenses BCN Service Company to offer certain products and services under the Blue Cross and Blue Shield names.

• BCN Service Company is an independent organization governed by its own board of directors and solely responsible for its own debts and other obligations.

• Neither the association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of BCN Service Company’s obligations.

• BCN files an annual report with the Michigan Department of Insurance and Financial Services. Find our annual statement online at mi.gov/difs by entering “HMO financial information” in the search box.

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

Decisions on a member’s care and service are based solely on the appropriateness of care prescribed in relation to each member’s specific medical condition.

Our clinical reviewers do not have financial arrangements that encourage denial of coverage or service. Nurses and physicians employed by BCN do not receive bonuses or incentives based on their review decisions. Medical review decisions are based strictly on medical necessity and providing high-quality care for members within the limits of a member’s plan coverage.

We monitor the care you get
BCN Service Company’s primary goal is to help you receive appropriate medical care from your physician. Our medical review staff are in close communication with your physician. We routinely monitor data to identify potential underuse of health care services.

We would like you to know:

• By contract, physicians who are contracted with BCN Service Company and BCN are required to make decisions about your care based only on your individual health care needs.
About BCN Service Company

• We monitor members’ health care services to promote the physicians’ duty to provide the most appropriate care for their conditions.
• We do not advertise, market or promote specific products or services to you or your doctors when discussing a member’s health condition.
• We do not have any financial ownership arrangements with other entities engaged in advertising, marketing or providing goods and services. In limited circumstances, BCN Service Company or BCN may notify you of new products or treatment opportunities.
• Health care providers, including physicians and hospitals, are never paid for denying services.
• Our medical review staff do not have financial arrangements encouraging denials for medically necessary care or services.

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

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

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

For more information about how we select new health services, visit bcbsm.com. Enter Blue Care Network Policies and Practices in the Search box, located in the upper right corner of the Web page.

Tell us what you think
Occasionally, we send out satisfaction surveys and publications that have feedback cards for you to complete and return to us. Returning these surveys and cards help us fine tune the way we serve you.

Here’s how you can tell us how we’re doing:
• Fill out and return the satisfaction surveys or feedback cards you receive from us. You’ll see one on the inside back cover of this book, or you may get one in the mail.
• Call Customer Service and tell us what you think.
BCN Service Company is committed to open and honest communication with our members. As a member, you have rights and responsibilities. A right is what you can expect from us. A responsibility is what we expect from you.

All members have the right to...

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

– Information about the financial relationships between BCN Service Company, BCN and a participating provider

– A Certificate of Creditable Coverage at any time during membership and up to 24 months after BCN coverage ends by calling Customer Service or by writing to:
  Blue Care Network
  P.O. Box 5184
  Southfield, MI 48086

All members have the responsibility to...

• Read their Benefit Document and applicable amendments, their Member Handbook and all other materials for members, and call Customer Service with any questions.

• Coordinate all nonemergency care through their primary care physician.

• Use the BCN provider network unless otherwise referred and approved by BCN and their primary care physician.

• Comply with the plans and instructions for care that they have agreed to with their practitioners.

• Provide, to the extent possible, complete and accurate information that BCN and its practitioners and providers need in order to provide care for them.

• Make and keep appointments for nonemergent medical care or call their doctor’s office if they need to cancel an appointment.

• Participate in the medical decisions regarding their health.

• Be considerate and courteous to practitioners, providers, their staff, other patients and BCN staff.

• Notify BCN of address changes and additions or deletions of dependents covered by their contract.

• Protect their identification card against misuse and call Customer Service immediately if a card is lost or stolen.

• Report to BCN all other health care coverage or insurance programs that cover their health and their family’s health.

• Participate in understanding their health problems and developing mutually agreed-upon treatment goals.
BCN Service Company and your primary care physician are interested in your satisfaction with the services and care you receive. If you have a problem relating to your care discuss this with your primary care physician first. Often your primary care physician can correct the problem to your satisfaction. You’re always welcome to call Blue Care Network Customer Service with any question or problem you have. BCN Service Company partners with BCN to support your coverage with customer service and appeals and grievances.

If you’re not able to resolve your issue by calling us, we have a formal process that you can use. You have two years from the date of discovery of a problem to file a grievance or appeal a decision of BCN Service Company. 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: 1-888-458-0716

**Step One**
We’ll review your concern and reply within 15 calendar days for preservice claims and within 20 calendar days for postservice claims. The individuals who review the first-level appeal are not the same ones involved in the initial decision. If we deny your appeal, we’ll write to you and explain the reasons for the denial and the next steps in the grievance process. At your request and at no charge to you, we’ll provide all documents and records used in making the decision.

**Step Two: Review 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 preservice and postservice claims, you’ll be notified of the Step Two grievance decision within 15 calendar days.

If we fail to provide a final decision within 30 calendar days for preservice or 35 calendar days for postservice claims (plus 10 business days if we ask for additional medical information) from the date we receive the written grievance, you may request an external review.
Expeditied review
Under certain circumstances — if your medical condition would be seriously jeopardized during the time it would take for a standard grievance review — you can request an expedited review. You, your doctor or someone acting on your behalf can initiate an expedited review by calling the Customer Service number on the back of your card or faxing us at 1-888-458-0716.

We’ll decide within 72 hours of receiving both your grievance and your physician’s confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days.

For a complete copy of the grievance policy, which includes more detail about your appeal rights and how soon we must respond, go to bcbsm.com/BCNresolveproblems or call Customer Service at 1-800-662-6667 from 8 a.m. to 5:30 p.m. Monday through Friday. TTY users can call 1-800-257-9980.

Other steps
As a member enrolled in a self-funded ERISA group plan, you have the right to an external review by an Independent Review Organization. To appeal our decision you must notify us in writing, and we will randomly assign the review to one of our three contracted IROs. The IRO decision is binding, and we will be responsible for all costs incurred. You must exhaust this process before filing a law suit.
Your Benefit Document and Amendments contain the terms and conditions of your coverage. They are the contract between you, your group and Blue Care Network.

Your Benefit Document has two parts: General Provisions and Your Benefits. These documents detail your benefits and define any exclusions and limitations.

Amendments to the Benefit Document add specific services and eliminate or restructure benefits.
UNIVERSITY OF MICHIGAN
GRADCARE BENEFIT DOCUMENT

BCN Service Company
A licensed third party administrator

This Benefit Document describes the benefits provided under your Coverage. It is made up of two chapters: General Provisions and Your Benefits and may be amended at any time, upon mutual agreement between the University of Michigan, the University of Michigan Medical Benefits Plan (“Group Health Plan”) and BCN Service Company (‘BCNSC’).

BCNSC is a licensed third party administrator (“TPA”) and independent licensee of the Blue Cross® Blue Shield® Association (‘BCBSA’). BCNSC’s license with BCBSA permits BCNSC to use the Blue Cross® Blue Shield® Service Marks in Michigan.

BCNSC is a Michigan nonprofit corporation and a wholly owned subsidiary of Blue Care Network of Michigan (‘BCN’).

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

General Provisions and Your Benefits describe the benefits provided under your Coverage in accordance with the ASC.

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

The Group Health Plan is self-funded, which means that the benefits are paid from the University's funds and are not provided through an insurance contract. This document, along with any booklets and/or guidelines provided by the University of Michigan Benefits Office, or eligibility and enrollment policies maintained by the University of Michigan Benefits Office, serve as the Group Health Plan document. Please read these documents carefully and keep them with your personal records for future reference. Policies, booklets and/or guidelines may be accessed at the University of Michigan Benefits Office website at http://www.umich.edu/-benefits/. The University of Michigan Benefits Office reserves the right to interpret and resolve conflicts between any statements in this GradCare Benefit Document that conflict with University of Michigan Benefits Office policies, booklets, summaries or other benefit related documents.

The University of Michigan has delegated the responsibility and discretionary authority to provide a full and fair review of Members’ benefit claims to BCNSC, however, neither BCNSC nor its subcontractors, including BCN are responsible for insuring coverage for your benefits under GradCare.
Blue Care Network of Michigan (BCN)

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

Definitions

These definitions will help you understand the terms used in this Benefit Document and are of general applicability to the entire document. Additional terms may be defined in subsequent sections of this document as necessary. In addition to these terms, “we”, “us” and “our” refer to BCNSC. The terms “you” or “your” refer to the Member, which may be enrolled as either a Contract Holder 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 of time after treatment by medical or surgical intervention.

Amendment describes any changes (additions, modifications, deletions, or revisions) to the Benefit Document that is requested by the Group and Group Health Plan. An Amendment may apply a Copay, Deductible, Coinsurance or Out-of-Pocket Maximum to select Covered Services. When there is a conflict between the Benefit Document and the Amendment, the Amendment takes precedence.

Approved Amount also known as the Allowed Amount is the lower of the billed charge or the maximum payment level BCNSC will pay for the Covered Services. Copayments 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 also 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.

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

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

Benefit Document is this booklet that describes the Coverage available to you.

Blue Care Network (BCN) is the Michigan health maintenance organization that has contracted with BCNSC to provide administrative services to support your Coverage described in this Benefit Document.

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

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

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

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

**Coordination of Benefits (COB)** means a process of determining which Benefit Document or policy is responsible for paying benefits for Covered Services first (primary plan). When you have dual coverage, this allows the secondary plan to reduce its benefits, so that the combined benefits of all plans do not exceed the total allowable fees. Benefit payments are coordinated between the two carriers to provide 100% coverage whenever possible for services covered in whole or in part under either plan, but not to pay in excess of the 100% of the total allowable amount to which you, as the Member, or the provider is entitled.

**Copayment or Copay** is a fixed dollar amount you must pay for a certain Covered Services usually when you receive the service. Your Copay is revised when an Amendment is attached. Copay amounts might be different for different health care services. For example, your Emergency room Copay might be higher than your office visit Copay.

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

**Custodial Care** is care primarily used to help the patient with activities of daily living or meet personal needs. Such care includes help with walking, getting in and out of bed, bathing, cooking, cleaning, dressing and taking medicine.

**Deductible** is the amount that you must pay before BCNSC will pay for Covered Services.

**Dependent Child** is an eligible individual less than the age of 26 who is the son or daughter in relation to the Contract Holder or spouse by birth or legal adoption or for whom the Contract Holder or spouse has legal guardianship. Note: A Principally Supported Child in not a Dependent Child for the purposes of this Benefit Document. See definition of Principally Supported Child below.

**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 Emergency and Urgent Care section)

**Enrollment** is the process of the Contract Holder providing completed enrollment information to the Group Health Plan and the Group Health Plan transmitting that information to BCNSC or its agent, BCN.

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

**Family Dependent** is an eligible family Member who is enrolled for health care Coverage. A Family Dependent includes Dependent Children and a Dependent under a Qualified Medical
Child Support Order, but does not include a Principally Supported Child. Family Dependents must meet the requirements stated in the General Provision Section 1.2.

**General Provisions** is Chapter 1 of this Benefit Document that describes the rules of your health care Coverage.

**Grievance** is a written dispute about coverage determination that you submit to BCNSC.

**Group** is the University of Michigan.

**Group Health Plan** means the medical benefits plan provided by the University of Michigan.

**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 abuse, psychiatric disorders or pulmonary tuberculosis.

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

**Level 1** refers to benefits for services provided by the Member's Primary Care Physician; or referred by the PCP and performed by a Participating Provider.

**Level 2** refers to benefits for services provided by any Provider outside of the GradCare Service Area as part of an approved off-site academic course of study or other field placement.

**Level 3** refers to benefits for services provided by a Provider outside the GradCare Service Area without a referral from the Member's Primary Care Physician when a Member is traveling temporarily outside the GradCare Service Area (e.g., during a school break.) Member is responsible for any balance billed amounts billed by the Provider that exceed the Approved Amount.

**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 end. It may be related to an illness but is distinctly separate. (Example: a Member may have Chronic arthritis of the knee but may have an acute flare-up 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 back 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:

- Rendered in accordance with generally accepted standard of medical practice (standards that are based on credible scientific evidence published in peer-review medical literature generally recognized by the relevant medical community, physician or provider society; recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors);

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and also
considered effective for the member’s illness, injury or disease;

- Not primarily for the convenience of the member or health care provider;
- Not regarded as experimental by BCN; and
- In accordance with BCN Utilization Management Criteria for Mental Health and Substance Abuse 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 services under the law or jurisdiction in which treatment is received.

**Non-Participating or Non-Participating Provider means** an individual provider, Facility, or other health care entity which is neither employed by or under contract with BCNSC and BCN. Unless the specific service is Preauthorized as required under this Benefit Document, the service will not be payable by BCNSC. You may be billed by the Non-Participating Provider and will be responsible for the entire cost of the service.

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

**Open Enrollment Period** is a period of time set each year by the Group Health Plan when you may enroll in or disenroll from the Group’s sponsored Coverage options.

**Other Qualified Adult** is an adult individual who satisfies all of the eligibility criteria under the University of Michigan’s Other Qualified Adult (OQA) program.

**Participating Provider** is an individual, Facility or other health care entity which is either employed by BCN or has contracted with BCNSC and BCN to provide you with Covered Services and has agreed not to seek payment from you for Covered Services except for permissible Copayment, if applicable.

**PCP Referral** is the process by which the Primary Care Physician directs you to a Referral Physician prior to a specified service or treatment plan. The PCP coordinates the Referral and any necessary BCN authorization.

**Preauthorization, Prior Authorization or Preauthorized Service** is health care Coverage described in this Benefit Document and authorized or approved by your Primary Care Physician (PCP) and/or BCN prior to obtaining the care or service except in an Emergency. Preauthorization is not a guarantee of payment.

**Primary Care Physician (PCP)** is a Level 1 Participating Provider who you choose to provide or coordinate all of your medical health care, including specialty and Hospital care. The Primary Care Physician is appropriately licensed in one of the following medical fields:

- Family Practice;
1.1.2014

General Practice;

Internal Medicine; and

Pediatrics.

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

**Professional Services** are services performed by a licensed practitioner, including, but not limited to practitioners with the following licenses:

- Doctor of Medicine;
- Doctor of Osteopathic Medicine;
- Doctor of Podiatric Medicine;
- Fully-licensed psychologist;
- Certified nurse midwife;
- Applied Behavioral Analyst;
- Physician Assistant; and
- Nurse Practitioners.

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

**Registered Member** is a Member who is outside of the GradCare Service Area as part of the approved off-site academic course of study or other field placement and has completed an Out of Area Academic Study/Field Placement Registration Form that has been accepted by BCN Service Company.

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

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

**Service Area** is the geographic area made up counties or parts of counties, where we have been authorized by the state of Michigan to market and sell our health plans and where the majority of our Participating Providers are located.

**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 and certified nursing home that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

**Urgent Care Center** is a Facility that provides services that are a result of an unforeseen sickness, illness, injury, or the onset of Acute or severe symptoms. Urgent Care Centers are not same as a Hospital Emergency department or doctor’s offices.

**Your Benefits** is Chapter 2 that provides a detailed description of Coverage, including exclusions and limitations.
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CHAPTER 1 - GENERAL PROVISIONS

Section 1: Eligibility, Enrollment & Effective Date of Coverage

All Contract Holders must meet eligibility requirements set by BCNSC and the University of Michigan.

All Members must live in the Service Area unless stated otherwise in this chapter.

1.1 Eligibility

University of Michigan is responsible for determining eligibility. BCNSC does not make eligibility determinations, but updates its files to record eligibility information provided by the University of Michigan. Please contact the University of Michigan Benefits Office for eligibility information.

1.2 Additional Eligibility Guidelines

The following guidelines apply to all GradCare Members:

- **Medicare**: If you are not an active employee and become eligible to enroll in Medicare, you are eligible to enroll in only the amended U-M Premier Care Plan that coordinates coverage with Medicare. If you are not an active employee, you or your Family Dependent must enroll in and maintain both Medicare Part A and Medicare Part B when you are eligible. Except as otherwise provided by applicable law, benefits for Members eligible for Medicare coverage are not duplicated. If Medicare is the primary payor or would be the primary payor if you or your Family Dependent enrolled in Medicare, your benefits will be reduced accordingly.

- **Out of Service Area**: A Family Dependent choosing to register for out of service area coverage must reside at least 50 miles outside of the Service Area. In addition, for coverage, Family Dependents are required to receive services within 50 miles of the out of service area address registered with BCN. For additional information on registration procedures, please call BCN Customer Service at number listed in the Member Handbook or on the ID Card.

This does not change any other conditions of Coverage described in the Benefit Document. For example, health care services are Covered Services only if and to the extent they are:

- Medically Necessary, as determined by BCN; and
- Listed in Section 8 (Your Benefits) of the Benefit Document; and
- Not limited or excluded under Section 9 (Exclusions and Limitations).

Certain services are Covered Services only if they are Prior Authorized by BCN. Family Dependents may receive information about which services require authorization by contacting BCN Customer Service at the number listed in the Member Handbook or on the ID Card.

A Family Dependent must notify BCN before receiving any services from a non-Contracted provider that require prior authorization. A Family Dependent who does not receive prior authorization from BCN when required under this Benefit Document will be responsible for payment in full (100%) of the cost of those services.

The following Family Dependents are not covered.
– Family Dependents who are outside of the service area for vacation.
– Family Dependents who reside outside the service area to attend school for less than one semester, or less than three (3) months.
– Family Dependents who are not students and reside outside the Premier Care Provider Network I area for less than three (3) months.
– Individuals who misrepresent that they are residing out of the Service Area are not covered.
– Family Dependents who are not residents of the United States (or the portion of Canada within 50 miles of the Service Area).

• **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 were admitted to a hospital or skilled nursing facility** prior to the effective date of this Benefit Document you will be covered for inpatient care on the effective date of Coverage only if:
  – You have no continuing coverage under any other health benefits contract, program or insurance;
  – BCNSC or BCN authorizes inpatient care as Medically Necessary upon notification of admission; and
  – Your medical management is transferred to your BCN Primary Care Physician before or on the effective date.

**Section 2: Other Party Liability**

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

• Are not provided or pre-authorized by BCN and a Primary Care Physician; or
• Are not Covered Services under this Benefit Document.

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

**2.1 Nonduplication**

• BCNSC Coverage provides you with benefits for health care services as described in this Benefit Document.
• BCNSC does not duplicate benefits or pay more for Covered Services than the actual fees. This includes no duplicate benefits paid for no-fault auto related claims.
• Coverage described in this Benefit Document will be reduced to the extent that the services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for the payment under such health plan or policy.
2.2 **Workers’ Compensation Claims and No-Fault Auto**

- Benefits under this Benefits Document exclude services and treatment for any work related injury to the extent that benefits are paid or payable under any workers’ compensation program or other similar program. Where services are provided by Group Health Plan, Group Health Plan is assigned the Member’s rights to seek reimbursement from the other program or insurer.

- Benefits under this Benefit Document will not be reduced because of the existence of coverage under a Member’s coordinated no-fault automobile policy. The Health Plan will assume primary liability for services that are available under this Benefit Document in accordance with Benefit Document’s terms and conditions if the Member has purchased a coordinated no-fault policy. If the Member has coverage through a non-coordinated no-fault policy, the Group Health Plan will not assume primary liability and will pay as a Secondary Plan.

2.3 **Coordination of Benefits (COB)**

**Definitions:**

"Benefit Document" and "Policy" for purposes of this Section 2.3 mean a benefit document, contract or policy issued by:

- A health or medical care corporation;
- A hospital physician corporation;
- A health maintenance organization;
- A dental care corporation;
- An insurance company;
- A labor-management trustee plan;
- A union welfare plan;
- An employer organization plan; or
- An employer self-insurance plan.

In connection with an Employer’s disability benefit plan under which health, dental, hospital, medical, surgical or sick care benefits are provided to Contract Holders.

"Coordination of Benefits" means determining which benefit document or policy is responsible for paying benefits for Covered Services first (Primary Plan) when you have dual coverage. This allows the Secondary Plan to reduce their 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 100% of the total allowable amount entitled to you, as the Member, or the provider.

"Determination of Benefits" means determining the amount that will be paid for Covered Services.

"Primary Plan" means the plan whose benefits for a person's health care coverage must be determined first, without taking into consideration coverage available under another plan.
"Secondary Plan" means a plan that is not the Primary Plan, and which is allowed to reduce benefits to the extent the benefits were paid or payable by the Primary Plan, so that the carrier’s combined payment does not exceed 100% of the total allowable amount to which the provider or you are entitled.

**Order of Benefits Determination (which policy will pay first)**

When you have coverage under a benefit document 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 BCNSC Coverage.

After those benefits are determined, the University of Michigan’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.

When you have coverage under another policy that does have a coordination of benefits provision, these rules apply:

1) The benefits of the policy that covers the person as Contract Holder (policy-holder) will be determined first. The benefits that cover the person as a dependent will be determined second.

2) Except in the case of minor children, if two policies cover a person as a dependent, the policy of the person whose birthday falls earlier in the calendar year will be considered primary, i.e., those benefits will be determined first.

3) Except in the case of minor children, if two policies cover a person as a dependent and the birthdays of the two policy-holders are identical, the policy that has been in effect longer will be primary.

**NOTE:** With regard to Paragraphs 2 and 3 above, if either policy is lawfully issued in another state, and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries, and each policy determines its payment of benefits after the other, the policy that does not have the COB procedure based on birthdays will determine who pays first.

4) If the services are rendered to a dependent minor child that is covered by more than one plan, the order of benefits is as follows:

   a) The Primary Plan is the plan of the parent whose birthday falls earlier in the year (or the plan that has been in effect the longest if both parents have the same birthday) when:
      - The Parents are married or living together;
      - A court decree awards custody to both parents without specifying who has responsibility to provide the child’s health care expenses or health insurance coverage;
      - A court decree states that both parents are responsible for the child’s health care expenses or health insurance coverage.

   b) The Primary Plan is the plan of the parent decreed by a court to be responsible for the
child's health care expenses or health insurance coverage if the child's parents are divorced, separated or not living together.

NOTE: Failure to give notice within 30 days of a court decree that requires you to be responsible for a dependent child's health care expenses or health insurance coverage may result in a denial of benefits.

c) If there is no court decree or the court decree awards something other than joint custody and/or is silent as to health care expenses or health insurance coverage, the order of benefits shall be determined as follows:
   1) The plan of the custodial parent;
   2) The plan of the spouse of the custodial parent;
   3) The plan of the non-custodial parent;
   4) The plan of the spouse of the non-custodial parent.

5) Active/inactive employee – The Plan that covers a Member as an employee who is either laid-off or retired or as that employee's dependent determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee’s dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.

6) Longer/shorter length of coverage – If none of the above determines the order of benefits, the plan that has covered an employee, member, or Contract Holder longer determines benefits before the plan that has covered that person for a shorter time.

Coordination with Medicare
If you have coverage with Medicare, payment will be made by BCNSC in accordance with the Medicare Secondary Payer Laws. If you are not an active employee and are eligible for Medicare Parts A and/or Part B and have not enrolled in coverage, your benefits will be reduced as if you were enrolled and covered by Medicare.

Continuation Coverage
If you have group continuation coverage (for example under COBRA or any state or federal law) and coverage under another plan, the plan that covers you as an active employee or as a dependent of an active employee is primary. The plan that provides continuation coverage is secondary.

COB Exception
Except as otherwise stated in this Benefit Document, Benefits will not be reduced or otherwise limited because of a non-group contract that is issued as a hospital indemnity, surgical indemnity, specified disease or other policy of disability insurance as defined in section 3400 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.3400 of the Michigan Compiled Laws.

COB Administration
- If it is determined that benefits under this benefit document should have been reduced because of benefits available under another benefit document or policy, BCNSC has the
right to:
- Recover from you any payments made to you; or
- Recover from the provider who received the payment.

- If benefits that should have been paid by BCNSC have been provided under another benefit document or policy, BCNSC may directly reimburse the provider of services. The provider will reimburse the other payer.
- For COB purposes, BCNSC may release, claim or obtain any necessary information from any insurance company or other organization. Any Member who claims benefits payment under this benefit document must furnish BCNSC with any necessary information or authorization to do this.
- In general, all terms and conditions of this Benefit Document - including applicable referral and authorization requirements - apply when BCNSC is the primary care or when BCNSC is providing secondary coverage. However, BCNSC may waive referral or authorization requirements when the secondary balance liability is for office visit Copayment or for other cost sharing that represents less than 50% of the Approved Amount for the service provided.

2.4 Subrogation and Reimbursement

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

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

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

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

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

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

"First Priority Security Interest" means the right to be paid before any other person from any money or other valuable consideration recovered by:
- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment
"Lien" means a first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCNSC paid as a result of plaintiff’s injuries.

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

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

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

**Your Responsibilities**

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

- You assign to us your right to recover what BCNSC paid for your medical expenses for the purpose of subrogation. You grant BCNSC a Lien or Right of Recovery. Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.
- You agree to inform BCNSC when your medical expenses should have been paid by another party but was not due to some act or omission.
- You agree to inform BCNSC when you hire an attorney to represent you, and to inform your attorney of BCNSC’s right and your obligations under this Benefit Document.
- You must do whatever is reasonably necessary to help BCNSC recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining a written consent from BCNSC if payment was made for the treatment you received for that injury.
- You agree to cooperate with BCNSC in the efforts to recover money paid on your behalf.
- You acknowledge and agree that this Benefit Document supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.

**Section 3: Member Rights and Responsibilities**

**3.1 Confidentiality of Health Care Records**

Your health care records will be kept confidential by BCNSC, its agents and the providers who treat you.

You agree to permit providers to release information to BCNSC and BCN. This can include medical records and claims information related to services you may receive or have received. BCNSC agrees to keep this information confidential, 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 BCNSC by providing health history information and helping to obtain prior medical records at the request of either BCNSC or BCN.

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

3.3 Primary Care Physician
You are required to select a Primary Care Physician from the list of Participating physicians. We will make every attempt to honor your choice.

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 prior authorization 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 1-800-6588878 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)

3.4 Refusal to Accept Treatment
You have the right to refuse treatment or procedures recommended by Participating Providers for personal or religious reasons. However, your decision could adversely affect the relationship between you and your physician, and the ability of your physician to provide appropriate care for you.
If you refuse the treatment recommended, and the Participating Provider believes that no other medically acceptable treatment is appropriate, the Participating Provider will notify you. If you still refuse the treatment or request procedures or treatment that BCN and/or the Participating Provider regard as medically or professionally inappropriate, treatment of the condition or complications caused by failure to follow the recommendations of the Participating Provider will no longer be payable under Coverage and this Benefit Document.

3.5 Complaint and Grievance Procedure
If you have a complaint or grievance regarding any aspect of the services received, you must follow the Group Health Plan grievance procedure. This is a two step internal process that is explained in your Member Handbook. You also may obtain a copy at any time by contacting BCN at 1-800-658-8878. You have two years from the date of discovery of a problem to file the grievance or appeal a decision.

3.6 Additional Member Responsibilities
You have the responsibility to:
- Read the Member Handbook, this Benefit Document and all Group Health Plan documents, and call Customer Service for any questions.
- Comply with the plans and instructions for care that you have agreed on with your practitioners.
- Provide, to the extent possible, complete and accurate information that BCNSC, BCN and Participating Providers need in order to provide you with care.
- Make and keep appointments for non-emergent medical care. You must call the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and 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, medical questionnaires or other forms that, as applicable, Group Health Plan, BCNSC or BCN requests. You warrant that any information you submit is true, correct and complete. The submission of false or misleading information to Group Health Plan, BCNSC or BCN in connection with Coverage is cause for Rescission of your contract within 30 days written advance notice. You have the right to appeal the decision to Rescind your Coverage by following the Complaint and Grievance procedure or by contacting Customer Service. Forms are available on the University of Michigan Benefits website at http://benefits.umich.edu/forms/index.html.

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

To be entitled to 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 you have not received your card or your card is lost or stolen, please contact Customer Service immediately by calling the number provided in the Member Handbook. Information regarding how to obtain a new ID card is also available at bcbsm.com.

4.3 Misuse of Identification Card
BCNSC may confiscate your ID card and may terminate Coverage if you misuse your ID card by doing any of the following:

- Repeatedly fail to present the card when receiving services from a provider,
- Permit any other person to use the card, and/or
- Attempt to or defraud BCNSC, BCN or a provider.

4.4 Enrollment Records

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

4.5 Authorization to Receive Information

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

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

4.6 Member Reimbursement
Your Coverage is designed to avoid the requirement that you pay a provider for Covered Services other than Copayment and/or deductible when applicable. If, however, circumstances require you to pay a provider, BCNSC will reimburse you for those Covered 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 BCNSC.
Section 5: Termination of Coverage

5.1 Termination of Coverage
Coverage described in this Benefit Document will continue in effect for the period of time the ASC remains in effect. The ASC and Coverage continue from year to year, subject to the rights of Group, Group Health Plan and BCNSC to terminate the ASC. Benefits for all members of the group will terminate on the date the Benefit Document terminates as permitted by law.

5.2 Termination for Nonpayment

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

Nonpayment of Member Copayment and Deductible
BCNSC may terminate Coverage under the following conditions:
- If you fail to pay Copayments 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 BCNSC.

5.3 Termination of a Member’s Coverage
a) Termination: Coverage for any Member 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.
- The Group’s Coverage is cancelled.
- You do not cooperate with BCNSC or BCN in pursuing subrogation.
- You are unable to establish a satisfactory physician-patient relationship.
- You act in an abusive or threatening manner toward BCNSC, BCN or Participating Providers, their staff, or other patients.
- Misuse of the BCNSC ID card (Section 4.3) that is not fraud or intentional misrepresentation of a material fact.
- Misuse of the BCNSC or BCN system that is not fraud or intentional misrepresentation of a material fact.

b) 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, we will consider you in breach of contract and, upon 30 days written advance notice your membership may be Rescinded. In some circumstances, fraud or intentional misrepresentation of a material fact may include:

- Misuse of the BCNSC ID card (Section 4.3);
- Intentional misuse of the BCNSC or BCN system; or
- Knowingly providing inaccurate information regarding eligibility.

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

5.4 Extension of Benefits
Your rights to BCNSC benefits end on the termination date except:

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

As noted in Section 1, Benefits are only provided when Members are eligible and covered under this Benefit Document. However, as permitted by law, this extension of Benefits will continue only for the condition being treated on the termination date, and only until any one of the following occurs:

- You are is discharged;
- Your benefits exhausted prior to the end of the contract; or
- You become eligible for other coverage.

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 BCNSC Coverage eligibility requirements as described in this Benefit Document under Section 1, you must transfer to an alternate benefit program offered by Group Health Plan, 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 Cross Blue Shield of Michigan or Blue Care Network of Michigan, Inc. You may contact BCN customer service to obtain additional information.

6.2 COBRA Coverage
If you no longer meet the eligibility requirements as described under Section 1 of this Benefit Document, 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 the University of Michigan Benefits Office.
NOTE: Employers under 20 employees, church-related groups and federal employee groups are exempt from COBRA.

As the University of Michigan is required by COBRA to offer qualified beneficiaries as defined under the federal COBRA law 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 the University of Michigan, 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.
     - The University of Michigan no longer includes BCNSC Coverage as a part of its Group Health.
     - Member begins coverage under any other benefit program or health coverage plan (with some exceptions).
     - After electing COBRA continuation, Member becomes eligible for Medicare.
     - Member fails to pay for Coverage fully and on time.

Section 7: General Provisions

7.1 Notice
Any notice that BCNSC is required to give to you will be
   - In writing;
   - Delivered personally or sent by U.S. Mail; and
   - Addressed to your last address provided to BCNSC.

7.2 Change of Address
You must notify the University of Michigan immediately if your address changes. You must live in the Service Area at least 8 months out of each calendar year. (See Section 1.)

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

7.4 Execution of Contract of Coverage
By accepting any benefit under this Benefit Document, you indicate your agreement to all terms, conditions, and provisions of Coverage as described in this Benefit Document.
7.5 Assignment
The Coverage is for your personal benefit. Coverage cannot be transferred or assigned to another person.

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

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

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

7.8 Reliance on Verbal Communications and Waiver by Agents
Verbal verification of your eligibility for Coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, Medical Necessity verification, and the availability of Coverage at the time the claim is processed, as well as to the conditions, limitations, exclusions, maximums, Copayment, and Deductible under Coverage.

No agent or any other person, except individuals so designated by Group Health Plan, has the authority to do any of the following:
- Waive any conditions or restrictions of Coverage.
- Extend the time for making payment.

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

7.9 Amendments
Coverage is subject to amendment, modification or termination in accordance with the terms of the Group Health Plan.
Such changes must be made in accordance with the terms of the ASC or by mutual agreement between the Group, Group Health Plan and BCNSC.

7.10 Major Disasters
In the event of major disaster, epidemic or other circumstances beyond the control of BCNSC, BCNSC will attempt to perform Covered Services insofar as it is practical, according to BCNSC’s best judgment and within any limitations of facilities and personnel that exist.
If facilities and personnel are not available, causing delay or lack of services, BCNSC will be excused from performing services in support of Coverage so long as the circumstances continue.

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

### 7.11 Obtaining Additional Information

The following information is available to you by calling Customer Service at 1-800-658-8878.

- 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 BCNSC and a Participating Provider.

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

### 7.12 Right to Interpret Contract

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

### 7.13 Out of Area Services

Services under this Benefit Document are covered only in the designated Service Area. 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 the Host Plan.

- **BlueCard Program** is a program that allows BCNSC to process claims incurred in other states through the Host Plan, subject to Blue Cross and Blue Shield Association policies.
**Designated Payment Level** is the amount used to calculate your BCNSC Copayment under the BlueCard Program as follows:

The amount is the lesser of:

- The provider’s billed charges for Covered Services; or
- The amount based on such factors 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 as stated in your Benefit Document or Amendments is considered final price.

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

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

**How Services are Paid**

If you receive Covered 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 and Copayment required under your Benefit Document or Amendments. After the Host Plan pays the provider, BCNSC reimburses the Host Plan the amount required under the BlueCard Program as provided for in the Designated Payment Level, described above.

If the provider is not a BlueCard Participating Provider, we will pay for the services as described in Section 8.

**What You Must Pay**

As a general rule, if your Covered Benefits include a Deductible, you will be responsible for payment of applicable Deductible for Covered Services at the time those services are received.

If your Covered Benefits include a Copayment, your Copayment for Covered Services processed under the BlueCard Program will be calculated using the Designated Payment Level.

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

**Exclusions and Limitations**

BlueCard does not apply if:

- The services are not a benefit under this Benefit Document.
- The services performed by a vendor or provider who has a contract with BCNSC 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. BCN Service Company (‘BCNSC’) has contracted with the University of Michigan and Group Health Plan to administer your Coverage.
- As discussed in the Introduction of this Benefit Document, BCNSC has arranged with Blue Care Network of Michigan (‘BCN’) to provide administrative services to support your Coverage, including customer service and responsibility for authorizations 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.
- Medical services provided in accordance with the terms of this Benefit Document are Covered Services only when they are Medically Necessary.
- Coverage is subject to the limitations and exclusions listed in Section 9 of this chapter.
- You are responsible for Copayment for many of the benefits listed.
- You are responsible for any amounts billed by Non-Participating Providers that exceed the Approved Amount when using Level 3 Services.
- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to a review of the diagnosis reported, verification of Medical Necessity, the availability of Benefits at the time the claim is processed, as well as the conditions, limitations, exclusions, maximums, Coinsurance, Copayments and Deductible under your Benefit Document and Amendments.
- Additional programs and services, which include but are not limited to, disease management, prevention, wellness, and care management services defined in your Member Handbook, are Benefits available to Members in addition to those set forth in this Benefit Document.

8.1 Out-of-Pocket Cost Sharing – Deductible, Copayment and Coinsurance Calculation

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

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you will pay for Covered Services under this Benefit Document per Calendar Year. The Out-of-Pocket Maximum includes your Level 1, Level 2 and Level 3 medical Cost Sharing. Once you reach the Out-of-Pocket...
Maximum, you do not pay for these services for the remainder of the Calendar Year with the following exceptions:

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

The Out-of-Pocket Maximum for Level 1, Level 2 and Level 3 medical Cost Sharing is combined. Copays and Coinsurance amounts (excluding prescription drugs) paid for all Covered Services under this Benefit Document apply towards the Out-of-Pocket Maximum.

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

**Out-of-Pocket Maximum**

$6,350 per Member
$12,700 per Family

**Level 1**
When you receive services from your PCP and only use other providers as arranged by your PCP, total out-of-pocket expenses will be limited to the set dollar Copayment amounts listed in this Benefit Document. When you receive services in Level 1 you will be responsible for payment of applicable Copayment at the time you receive the services. Payments for any service that is not covered by GradCare are entirely your responsibility. Payments for any unauthorized services requiring prior authorization or specialty care not referred by your PCP are also your responsibility.

**Level 2**
When you receive services from Providers outside of the GradCare Service Area and you registered your off site study with BCN, total out-of-pocket expenses will be limited to the set dollar Copayment amounts listed in this Benefit Document. When you receive services in Level 2 you will be responsible for payment of applicable Copayment at the time you receive the services. Payments for any service that are not covered by GradCare are entirely your responsibility. Payments for any unauthorized services requiring prior authorization are also your responsibility.

**Level 3**
When you are outside the GradCare Service Area on vacation or academic break, and you use a Provider without a referral from your Primary Care Physician, you will be responsible for the set dollar Copayment amount listed in this Benefit Document plus any amount over the Approved Amount. Payments for any service that is not covered by GradCare are entirely your responsibility. Payments for any unauthorized services requiring prior authorization are also your responsibility.
8.2 Professional (Physician) Services (Other Than Mental Health and Substance Abuse)

a) **Office Visits** - provided by your Primary Care Physician, Participating OB/GYN for female Members or a Referral Physician when services are rendered in an outpatient office site including visits at hospital locations.
   - Level 1 - $20 Copayment for each office visit
   - Level 2 - $20 Copayment for each office visit
   - Level 3 - $20 Copayment for each office visit
     • Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

b) **Maternity Care** - including prenatal and postnatal visits provided by your Primary Care Physician or Participating OB/GYN.
   - Level 1 - Covered in full
   - Level 2 - Covered in full
   - Level 3 - Covered in full
     • Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

c) **Home Visits** - provided by a physician in the home or temporary residence. For additional home health care services, please refer to Section 8.12.
   - Level 1 - Covered in full
   - Level 2 - Covered in full
   - Level 3 - Covered in full
     • Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

d) **Inpatient Professional Services** - Physician services provided while the Member is in an inpatient hospital or skilled nursing facility are covered except for services listed in this Benefit Document that have a specific Copayment.
   - Level 1 - Covered in full
   - Level 2 - Covered in full for emergency admission only
     • Not covered for non-emergent admissions
   - Level 3 - Covered for emergency admission only
     • Not covered for non-emergent admissions
     • Member is responsible for any amount billed by the Provider that exceeds the Approved Amount.

e) **Allergy Care** - Allergy testing, evaluation, serum, and injection of allergy serum.
   - Level 1 - $20 Copayment may apply to each office visit per Member. Injections covered in full
Level 2 - $20 Copayment may apply to each office visit per Member. Injections covered in full
Level 3 - $20 Copayment may apply to each office visit per Member
- Injections covered up to the Approved Amount
- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

8.3 Continuity of Care for Professional Services
Continuity of Care for Existing Members
Under Michigan law, when a contract terminates between BCNSC and Participating Provider (including your Primary Care Physician) who is 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 BCNSC of his or her agreement to accept the BCNSC Approved Amount as payment in full for the services provided 2) continues to meet BCNSC’s quality standards and 3) agrees to adhere to the BCNSC medical and quality management policies and procedures.

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

Medical Conditions and Coverage Time Limits:
- Pregnancy Related: If you are in your second or third trimester of pregnancy at the time of the treating physician’s disaffiliation, services provided by your physician may continue through post-partum care for Covered Services directly related to your pregnancy.
- Terminal Illness: If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the BCNSC contract end, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.
- Other Medical Conditions: For Chronic and Acute medical conditions when a course of treatment began prior to 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. Your Participating Primary Care Physician must coordinate all other services in order for them to be Covered Services.

Coverage:
If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the “Physician Requirements” listed above, BCNSC will continue to provide coverage 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 BCNSC’s Continuity of Care program. At the time of enrollment you must select a BCNSC 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.

8.4 Inpatient Hospital Services

The following inpatient Facility services are covered when Medically Necessary and Preauthorized by your PCP and BCN, unless they are listed elsewhere in this Benefit Document with specific Copayment.

a) Room and board, general nursing services and special diets;
b) Operating and other surgical treatment rooms, delivery room and special care units;
c) Anesthesia, laboratory, radiology and pathology services;
d) Chemotherapy, inhalation therapy and dialysis;
e) Physical, speech and occupational therapy;
f) Other inpatient services and supplies necessary for the treatment of the Member; and
g) Maternity care and routine nursery care of newborn (See Section 9 for exclusions).

NOTE: The mother and newborn child are covered for no less than the following length of stay in a hospital in connection with childbirth:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section
The hospital length of stay may be shorter if the attending provider, e.g., your physician or certified nurse midwife, after consultation with the mother, discharges the mother or newborn earlier.

**Coverage:**
- Level 1 - Covered in full
- Level 2 - Covered in full for emergency admission
  - Not covered for non-emergent admissions except maternity care and delivery of newborn
- Level 3 - Covered in full for emergency admission
  - Not covered for non-emergent admissions except maternity care and delivery of newborn

Certain hospital services have separate requirements and your Cost Sharing may be different. See for example coverage for Emergency room visits and urgent care visits.

**8.5 Outpatient Hospital Services**
Outpatient Facility services are covered when they are Medically Necessary and Preauthorized by your Primary Care Physician and BCN.
- Level 1 - Covered in full
- Level 2 - Covered in full
- Level 3 - Covered
  - Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Certain hospital services have separate requirements and your Cost Sharing may be different. See for example coverage for Emergency room visits and urgent care visits.

**8.6 Emergency Care Definitions:**
- **Accidental Injury** - a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.
- **Emergency Services** - services to treat emergency conditions as described above.
- **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.
- **Stabilization** - the point at which it is reasonably probable that no material deterioration of a condition is likely to result from or occur during your transfer.
- **Urgent Care Services** - services that appear to be required in order to prevent serious deterioration to your health resulting from an unexpected illness or injury that could be expected to seriously worsen if not treated within 24 hours. Examples include: flu, strop
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 and Urgent Care Services are covered up to the point of Stabilization when they are Medically Necessary and needed either 1) for immediate treatment of a condition that is a Medical Emergency as described above or 2) if the Primary Care Physician directs you to go to an emergency care Facility.

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

Emergency Services include professional and related ancillary services and Emergency services provided in an Urgent Care Center or hospital Emergency room. Emergency Services are no longer payable as an Emergency Service at the point of the Member's Stabilization as defined above.

If you are admitted as an Inpatient as a result of the Emergency, the Inpatient Hospital benefits as described in this Chapter will apply.

**Note:** Services and treatment provided while you are considered to be admitted for an Observation stay are subject to Emergency Services Copayment.

**Follow-up care in an Emergency Care Center or Urgent Care Facility** - such as removal of stitches and dressings, is covered when Preauthorized by BCN. This applies even if the Hospital Emergency staff or physician instructed you to return for follow-up.

**Level 1, Level 2 and Level 3 Copayment**

- $75 Copayment for Emergency Services provided in a hospital emergency room; waived if Member is admitted to hospital as a bed patient.
- $20 Copayment for Emergency Services in an urgent care center.

Follow-up care in an Emergency Care Center or Urgent Care Facility - such as removal of stitches and dressings, is covered only when Preauthorized by your Primary Care Physician or BCN.

**Emergency Services at a Non-Participating Hospital:**
If you are hospitalized in a Non-Participating Facility, we may require that you be transferred to a Participating Facility as soon as you are stabilized.

**Out-of Area Coverage:**
You are covered when traveling outside of the Service Area for Emergency Services that meet the conditions described above.
YOUR BENEFITS

8.7 Ambulance

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

The following ambulance services are covered in full:

- Air ambulance for emergency transport is covered to the nearest hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet the above requirements and must be verified by the records of the physician who treats you and by the ambulance company.

- 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. (The services are not covered 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 only when Preauthorized by your Primary Care Physician and BCN.

NOTE: Transportation 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. Medically necessary ambulance transport provided through local municipalities is covered.

Ambulance services provided by an emergency responder that does not provide on-site treatment and transportation are not covered.

8.8 Outpatient Professional Diagnostic and Therapeutic Services, Tests and Treatments

Coverage includes Medically Necessary therapeutic and diagnostic laboratory, pathology and radiology services, and other procedures for the diagnosis or treatment of a disease, injury or medical condition including but not limited to:

- Surgery;
- Injections;
- Chemotherapy; and
- Dialysis.

These outpatient Professional Services are covered when they are Medically Necessary and Preauthorized by your Primary Care Physician.
Level 1 and Level 2 services are covered in full except when they are listed in this Benefit Document with a specific Copayment.

**Coverage:**
- Level 1 - Covered in full
- Level 2 - Covered in full
- Level 3 - Covered
  - Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Certain hospital services have separate requirements and your Cost Sharing may be different. See for example genetic testing procedures, cosmetic and experimental procedures.

### 8.9 Preventive and Early Detection Services

a) **Preventive and Early Detection Services** - There is no Copayment and/or Coinsurance (if applicable) for Preventive Services as that term is defined in the federal Patient Protection and Affordable Care Act (PPACA) and as may be modified by the federal government from time to time. All other requirements of Coverage, such as required referrals or Preauthorizations apply.

Level 1, Level 2 and Level 3 Preventive Services include but are not limited to the following:

- **Health assessments, health screenings and adult physical examinations** set at intervals in relation to your age, sex and medical history. Health screenings include but are not limited to:
  - Obesity screening
  - Vision and hearing screening
  - Glaucoma screening;
  - EKG screening;
  - Type 2 diabetes mellitus screening, and
  - Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)

- **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
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covered when authorized by BCNSC. In such instances, the items must be purchased from a participating Durable Medical Equipment provider. Breast pumps are limited to no more frequent than one every 24 months. Convenience items such as storage containers, bags, bottles and nipples will remain not covered. To locate an affiliated DME provider, call the number on the back of your ID card;

- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening;
- Screening for gestational diabetes;
- Bone density screening;
- Genetic counseling and BRCA testing, if appropriate, for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes;
- Screening and counseling for interpersonal and domestic violence; and
- Female sterilization services.

- **Newborn and well-child assessments and examinations**
- **Immunizations** (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN. Flu shots are covered in full.
- **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.)
- **Depression screening** when performed by the Primary Care Physician
- **Nutritional counseling** including Diabetes Self-Management
  
  Note: Certain health education and health counseling services may be arranged through your Primary Care Provider, but are not payable under your Benefit Document. Examples include but are not limited to: birthing classes, lactation classes not provided by your physician, weight loss programs, tobacco cessation programs (other than a BCN tobacco cessation program), and/or exercise programs.
- **Aspirin therapy counseling** for the prevention of cardiovascular disease, and
- **Tobacco use** and tobacco caused disease counseling

**Note:** If your Benefit Document is amended by Deductible, Copayment and/or Coinsurance Amendments, the applicable Amendment will take precedence over the Benefit Document. Deductible, Copayment and/or Coinsurance (“Cost Sharing”) will apply to non-routine diagnostic procedures. Cost Sharing will still apply with the following restrictions:

- If a recommended Preventive 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 Service.
- If a recommended Preventive Service is not billed separately from the office visit and the primary purpose of the office visit is the delivery of the Preventive Service,
you will have no Cost Sharing for the office visit.

- If a recommended Preventive Service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of the Preventive Service, you will be responsible for payment of any Cost Sharing for the office visit.

**NOTE:** To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org). You may also contact BCNSC Customer Service by calling the number provided on the back of your ID card.

**b) Routine Vision Exam** performed by a participating optometrist, ophthalmologist or other provider to determine refractive error and to issue a prescription for corrective lenses (eyeglasses or contact lenses). Coverage is limited to one routine vision exam per Member per calendar year.

   - Level 1 - Covered in full
   - Level 2 and Level 3 - Covered up to $40.00 per Member per calendar year.

**Exclusions include but are not limited to:** Dilation, frames, lenses and contact lenses and contact lens fitting.

### 8.10 Reproductive Care and Family Planning Services

This benefit includes:

- Infertility;
- Voluntary sterilization;
- Termination of pregnancy;
- Reproductive care and family planning; and
- Genetic testing.

**a) Infertility**

Coverage includes diagnosis of and counseling for infertility when Medically Necessary and Preauthorized by your Primary Care Physician and 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.

   - Level 1 - $20 Copayment may apply to each office visit per Member
   - Level 2 - $20 Copayment may apply to each office visit per Member
   - Level 3 - $20 Copayment may apply to each office visit per Member

   - Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

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

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

b) Voluntary Sterilization
Coverage includes Inpatient, Outpatient, and office based adult sterilization services.

Female Sterilization is covered in full as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services.

Male sterilization
- Level 1 - $20 Copayment may apply to each office visit per Member
- Level 2 - $20 Copayment may apply to each office visit per Member
- Level 3 - $20 Copayment may apply to each office visit per Member

Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Exclusions include but are not limited to: Reversal of surgical sterilization for males and females.

c) Termination of Pregnancy
Coverage includes first trimester elective termination of pregnancy and therapeutic termination in the 2nd or 3rd trimester in accordance with locally accepted medical practice.

- Level 1 - $20 Copayment for each office visit
- Level 2 - $20 Copayment for each office visit
- Level 3 - Not covered

d) Reproductive Care and Family Planning
Coverage includes the following services when they are provided in accordance with generally accepted medical practice:
- History;
- Physical exam;
- Lab tests; and
- Advice and medical supervision related to family planning.

- Level 1 - $20 Copayment may apply per Member for each office visit
- Level 2 - $20 Copayment may apply per Member for each office visit
- Level 3 - $20 Copayment may apply per Member for each office visit

Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

e) 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.

Level 1 - $20 Copayment may apply per Member for each visit
Level 2 - $20 Copayment may apply per Member for each visit
Level 3 - $20 Copayment may apply per Member for each visit

- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

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

**Exclusions include but are not limited to:** Genetic testing and counseling for non-members

### 8.11 Skilled Nursing Facility Services

Skilled Nursing Facility Services are covered up to a total cumulative maximum of 45 days per calendar year when Medically Necessary for recovery from surgery, disease or injury. This Benefit includes hospice care in a Skilled Nursing Facility. The care must be Preauthorized by your Primary Care Physician and BCN.

**Coverage:**

- Level 1 – Covered in full
- Level 2 – Covered in full
- Level 3 – Covered

- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

**NOTE:** The maximum number of benefit days is 45 days per calendar year under Level 1, Level 2, and Level 3 combined. For example, use of a benefit day under Level 1 Coverage will also reduce the benefit days available under Level 2 and Level 3 Coverage.

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

- Bed-hold charges incurred when you are on an overnight or weekend pass during an Inpatient stay; and
- Basic custodial care.

### 8.12 Home Health Care Services

Home health care services are provided for Members, who are confined to the home, 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;
- Hospice care; and
- Other health care services approved by BCN when they are performed in the Member’s home.

**Coverage:**
Home Care services are covered when they are Medically Necessary.

- Level 1 - $20 Copayment each day a visit occurs
- Level 2 - $20 Copayment each day a visit occurs
- Level 3 - $20 Copayment each day a visit occurs
- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

**Exclusions include but are not limited to:**
- Housekeeping services; and
- Services for the purpose of providing Custodial Care.

### 8.13 Hospice Care

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

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

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

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

**Coverage:**
- Level 1 - Covered in full
- Level 2 - Not covered
- Level 3 - Not covered

**Exclusions include but are not limited to:**
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- Housekeeping services;
- Food, food supplements and home delivered meals; and
- Room and board at an extended care Facility or hospice Facility for purposes of delivering Custodial Care.

8.14 Home Infusion Therapy Services
Home infusion services provide the safe and effective 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 a 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.

  - Level 1 - Covered in full
  - Level 2 - Covered in full
  - Level 3 - Covered
    - Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

8.15 Mental Health Care/Autism Spectrum Disorder
Mental Health Care
Treatment for Mental Health illnesses must be provided in an approved Facility or by a Participating Provider and be Preauthorized as Medically Necessary except in an emergency. (See Section 8.6)

  - Coverage is limited to solution-focused treatment and crisis interventions. 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 illnesses or to those

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outpatient services that are Medically Necessary in order to prevent an Acute episode of a Chronic illness.

- Medical services required during a period of mental health admission must be authorized separately by your PCP and BCN.

**Definitions:**

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

- **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 evaluations and/or referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of inpatient psychiatric hospitalization.

**Coverage:**

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

a) **Outpatient Mental Health/Intensive Outpatient Mental Health**
   - Level 1 - $20 Copayment per visit
   - Level 2 - $20 Copayment per visit
   - Level 3 - $20 Copayment per visit

b) **Inpatient Mental Health/Partial Hospitalization**
   - Level 1 - Covered in full.
   - Level 2 - Covered in full for emergency admission only
     - Not covered for non-emergent admissions
   - Level 3 - Covered for emergency admission only
     - Not covered for non-emergent admissions

**NOTE:** See Section 9 for Exclusions and Limitations.
**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. AAEC evaluation is necessary for Applied Behavioral Analysis.

**Autism Spectrum Disorders** include Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

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

**Line Therapy** means tutoring or other activities performed one-on-one with person diagnosed with Autism Spectrum Disorder according to a Treatment Plan designed by a BCN Approved Autism Evaluation Center and a board certified Behavioral Analyst.

**Preauthorization** Process 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 Autism Spectrum Disorders covered under this Benefit Document.

**Benefits:**

Services for the diagnosis and treatment of Autism Spectrum Disorders, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified are covered when performed by an approved outpatient provider. Covered diagnostic services must be provided by a licensed physician or a licensed psychologist and include: assessments, evaluations or tests, including the Autism Diagnostic Observation Schedule. Services for the treatment of Autism Spectrum Disorders are covered as follows:

- Comprehensive treatment focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder.
- Therapeutic care as recommended in the treatment plan includes:
  - Occupational therapy, speech and language therapy and physical therapy (when performed by a licensed certified and contracted occupational therapist, speech therapist and physical therapist);
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- Applied Behavior Analysis (when performed by a contracted board-certified behavior analyst and licensed-certified psychologist);
- Outpatient mental health therapy (when performed by a licensed certified and contracted social worker, clinical psychologist and psychiatrist);
- Genetic testing; and
- 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-Approved Autism Evaluation Center that evaluated and diagnosed the Member's condition and when approved by BCN.

NOTE: Benefits are in addition to any outpatient mental health benefits and outpatient rehabilitation services available under this Benefit Document or related Amendments.

**Coverage:**
Benefits are available to children through the age of 18 years old for covered medical-surgical services, outpatient rehabilitation services and/or behavioral health services including the diagnostic therapeutic services described above. This age limitation does not apply to outpatient mental health services (excluding applied behavioral analyses services) and services used to diagnose Autism Spectrum Disorders.

ABA for Line Therapy services is subject to the Primary Care Physician office visit Copayment as defined in this Benefit Document. You are required to pay your Copay at the time the service is rendered.

Services are subject to any Copayments imposed under your coverage. If you have a Deductible, you are responsible for meeting the Deductible prior to BCNSC paying for Covered Services.

Behavioral health services included in the Treatment Plan are subject to the Primary Care Physician office visit Copayment as defined in this Benefit Document and applicable Amendments. You are required to pay your Copayment at the time the service is rendered.

Outpatient rehabilitation services included in the Treatment Plan are subject to the Level 1, Level 2 and Level 3 Referral Physician Copayment as defined in this Benefit Document and applicable Amendments. You are required to pay your Copayment at the time the service is rendered.

Services performed pursuant to the recommended Treatment Plan will not count toward benefit maximums defined in this Benefit Document including, but not limited to, visit or treatment limits imposed on speech-language pathology or occupational therapy. The Line Therapy Limit defined below will apply.

This Coverage overrides certain exclusions in your underlying Benefit Document such as exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities and treatment solely to improve cognition concentration.
and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought when a Member is being treated for covered Autism Spectrum Disorders.

**Limitations:**
Coverage is available subject to the following requirements:

- **Line Therapy** to treat Autism Spectrum Disorders is limited to 25 hours per Member per week. Psychiatric, psychological, physical therapy, speech-language pathology, occupational therapy, or non-applied behavioral analysis services, in addition to services for the diagnosis of autism are not subject to this limit.

- **Prior Authorization** - Level 1, Level 2 and Level 3 services performed under the recommended Treatment Plan must be approved for payment during BCN’s Prior Authorization Process. If Prior Authorization 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** - To receive lower out of pocket costs, Level 1, Level 2 and Level 3 services to treat Autism Spectrum Disorders must be performed by a BCN approved provider. All services to treat Autism Spectrum Disorders must be performed by a BCN approved provider. If services are rendered by a Non-Panel provider, you are responsible for any amount charged that exceeds the Approved Amount.

- **Required Diagnosis for Applied Behavior Analysis** - The Member must be evaluated and diagnosed with Autistic Disorder, Asperger’s Disorder, or Pervasive Developmental Disorder Not Otherwise Specified by a, psychiatrist, development pediatrician or other professional as agreed upon by a BCN Approved Autism Evaluation Center in order to receive authorization for ABA. Other authorization requirements may also apply. The requirement to be evaluated and diagnosed by a BCN Approved Autism Evaluation Center does not exist for other services related to Autism Spectrum Disorder.

- **Termination at age 19** - Benefits are limited to children up to and including the age of 18. This age limitation does not apply to outpatient mental health services (excluding applied behavioral analyses services) and services used to diagnose Autism Spectrum Disorders. Benefits for Autism Spectrum Disorder terminate on the child’s 19th birthday.

- **Treatment Plan** - Level 1, Level 2 and Level 3 services must be included in a Treatment Plan recommended by a BCN Approved Autism Evaluation Center 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 is excluded from coverage.
• Conditions such as Rett’s Disorder and Childhood Disintegrative Disorder are not payable under this benefit.

8.16 Substance Abuse Services/Chemical Dependency
Substance Abuse/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.

Substance Abuse/Chemical Dependency treatments must be provided in an approved Facility or by a Participating Provider and be Preauthorized as Medically Necessary except in an emergency. (See Section 8.6)

• 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 abuse admission must be authorized separately by your Primary Care Physician or by BCN.

Definitions:
• Detoxification means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detoxification (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 Abuse Treatment means day treatment that is provided on an outpatient basis. Intensive Outpatient services consists of a minimum of 3 hours per day, 2 days per week and might include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services specified in a treatment plan.
• Intermediate Care refers to substance abuse services that have a residential (overnight) component. Intermediate Care includes detoxification, domiciliary partial and residential (including “inpatient” and “rehab”) services.
• Outpatient Substance Abuse Treatment means outpatient visits (for example: individual, conjoint, family or group psychotherapy) for a Member who is dependent on and/or abusing alcohol or drugs (or both). The visit may include counseling, detoxification, medical testing, diagnostic evaluation and referral for other services.
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- **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 Abuse Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical hospitalization. Residential Services may include 24-hour professional supervision and may also include counseling, detoxification, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Residential Substance Abuse Treatment is sometimes also referred to as inpatient substance abuse treatment or rehabilitation (“rehab”).

**Coverage:**
Substance abuse services including counseling, medical testing, diagnostic evaluation and detoxification are covered in a variety of settings. You may be treated in an Inpatient or in an Outpatient setting. You can call BCN Behavioral Health Management available 24 hours a day, 7 days a week at the number provided on the back of your ID card to obtain services.

The following services are covered:

a) **Outpatient/Intensive Outpatient Substance Abuse Treatment**
   - Level 1 - $20 Copayment per visit
   - Level 2 - $20 Copayment per visit
   - Level 3 - $20 Copayment per visit

b) **Detoxification/Residential/Intermediate Care/Partial Hospitalization**
   - Level 1 - Covered in full
   - Level 2 - Covered in full for emergency admission only
   - Not covered for non-emergent admissions
   - Level 3 - Covered for emergency admission only
   - Not covered for non-emergent admissions

**NOTE:** See Section 9 for Exclusions and Limitations

**8.17 Outpatient Rehabilitation**
Outpatient rehabilitation is treatment for recovery from surgery, disease or injury which consists of the following:

- Physical therapy;
- Occupational therapy;
- Speech therapy; and
- Medical rehabilitation - includes but not limited to cardiac and pulmonary rehabilitation.

*Physical therapy, occupational therapy and speech therapy*
Short-term outpatient medical rehabilitation and physical, occupational and speech therapy are
covered when they are Medically Necessary for a condition that can be expected to improve significantly within benefit limitations. These services must be Preauthorized by your Primary Care Physician and BCN.

**Benefit Limitations:** Treatment for conditions considered to have a major diagnosis is limited to 60 visits per calendar year for any combination of physical, occupational, and speech therapy. Treatment for conditions that are considered to have a minor diagnosis is limited to 15 visits per calendar year for any combination of physical, occupational, and speech therapy. Major and minor diagnoses are determined by the Group Health Plan.

- Level 1 - $20 Copayment per session
- Level 2 - $20 Copayment per session
- Level 3 - $20 Copayment per session
- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

**NOTE:** The benefit days under Level 1, Level 2 and Level 3 are cumulative. For example, use of a benefit day under Level 1 Coverage will reduce the benefit days available under Level 1, Level 2 and Level 3 Coverage.

**General exclusions include but are not limited to:**
- Cognitive retraining;
- Vocational rehabilitation;
- Therapy to maintain current functional level and prevent further deterioration; and
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency.

**Additional exclusions for Speech therapy 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; and
- Treatment for children who would otherwise be eligible to receive speech therapy through school or a public agency.

**NOTE:** Speech therapy for life-style activities may be covered when Medically Necessary and condition is subject to improvement within benefit limitations.

**Cardiac Rehabilitation**
Covered up to 36 sessions during an 18 week period per Medical Episode
- Level 1 - $20 Copayment per Member per session
- Level 2 - $20 Copayment per Member per session
- Level 3 - $20 Copayment per Member per session
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- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

NOTE: The benefit days under Level 1, Level 2 and Level 3 are cumulative. For example, use of a benefit day under Level 1 Coverage will reduce the benefit days available under Level 1, Level 2 and Level 3 Coverage.

**Pulmonary Rehabilitation**
Covered up to 1 program of 12 sessions per year per condition
- Level 1 - $20 Copayment per Member per session
- Level 2 - $20 Copayment per Member per session
- Level 3 - $20 Copayment per Member per session

- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

NOTE: The benefit days under Level 1, Level 2 and Level 3 are cumulative. For example, use of a benefit day under Level 1 Coverage will reduce the benefit days available under Level 1, Level 2 and Level 3 Coverage.

### 8.18 Durable Medical Equipment and Diabetic Supplies

**Definitions:**
Diabetic supplies and equipment used for the prevention and treatment of clinical diabetes.

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

**Coverage:**
Rental or purchase of DME is limited to the basic equipment. Any supplies required to operate the equipment and special features that are considered Medically Necessary must be Preauthorized by BCN to be covered.

Basic diabetic supplies and equipment are covered when Medically Necessary, prescribed by the treating physician and obtained from an affiliated provider. Covered items include:
- Blood glucose monitors;
- Test strips for glucose monitors, lancets, and spring powered lancet devices, visual reading and urine test strips;
- Syringes and needles;
- Insulin pumps and medical supplies required for the use of an insulin pump; and
- Diabetic shoes and inserts.

In some instances BCNSC 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
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Service at the number provided on the back of your ID card.

Level 1 - Covered in full
Level 2 - Covered in full
Level 3 - Covered

- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

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

NOTE: Breast pumps are covered when Medically Necessary and obtained from a Participating Provider. (See Section 8.9 for additional information)

Exclusions include but are not limited to:
- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the patient and required so the patient can operate the equipment himself. (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 for the 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, 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, 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 or damage that can be repaired;
• Assistive technology and adaptive equipment such as computers, supine boards, prone standers and gait trainers;
• Modifications to your home, living area or motorized vehicles. This includes equipment and the cost of installation of equipment such as central or unit air conditioners, swimming pools and car seats; and
• All repairs and maintenance that result from misuse or abuse.

8.19 Prosthetics and Orthotics
Definitions:
Prosthetics are artificial devices that serve as a replacement of a part of the body lost by injury (traumatic) or missing from birth (congenital). Prosthetic devices can be either:
  – External: Prosthetic Devices - Devices such as an artificial leg, artificial arm or the initial set of prescription lenses for replacement of an organic lens of the eye following Medically Necessary eye surgery (e.g. cataract surgery) are considered external devices.
  or
  – Internal: Implantable Prosthetic Devices – Devices surgically attached or implanted during a Preauthorized surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, or implanted lens immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g. cataract surgery) are considered Internal devices.

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

Coverage:
Benefits for Prosthetics and Orthotics are covered only for the basic Prosthetic and Orthotic appliance and any Medically Necessary special features prescribed by the treating physician and Preauthorized by BCN. Coverage includes but is not limited to:
• Implantable or non-implantable breast prostheses required following a Medically Necessary mastectomy.
• Repair, replacement, fitting and adjustments are covered only when needed as determined by BCN resulting from body growth, body change or normal use. Repair of the item will be covered if it does not exceed the cost of replacement.
• The initial set of prescription lenses (eyeglasses or contact lenses) are covered as a Prosthetic device immediately following Preauthorized surgery for replacement of an organic lens of the eye (e.g., cataract surgery).
• Contact lenses for the diagnosis and treatment of Keratoconus.
• Shoe inserts and foot orthotics.

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

Level 1 - Covered in full
Level 2 - Covered in full
Level 3 - Covered
YOUR BENEFITS

- Member is responsible for any amount in excess of Approved Amount

**Limitations:**
- The item must meet the Coverage definition of a prosthetic or orthotic device and it must be Preauthorized by BCN.
- You must obtain the item or a BCN-approved supplier.
- The Primary Care Physician or a Participating Provider must prescribe the item.
- Coverage is limited to the basic items. If a deluxe item is requested, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the Member’s option. You are responsible for any costs over the Approved Amount for the different type of item that may be prescribed;
- Any special features that are considered Medically Necessary must be Preauthorized by BCN; and
- Replacement is limited to items that cannot be repaired or modified.

**Exclusions include but are not limited to:**
Repair or replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Also excluded, by example and not limitation, are the following:
- Sports-related braces;
- Dental appliances, including bite splints;
- Eyeglasses or contact lenses (except after lens surgery and for treatment of Keratoconus as listed above);
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, wigs and hairpieces;
- Over the counter arch supports, foot orthotics or shoe inserts that are not attached to a leg brace;
- Devices that are experimental and research in nature;
- Items for the convenience of the Member or caregiver; and
- Duplicate appliances and devices.

**8.20 Organ and Tissue Transplants**
An organ or body tissue transplant is covered when:
- It is considered non-experimental in accordance with generally accepted medical practice; and
- It is Medically Necessary and Preauthorized by BCN; and
- It is performed at a BCN-approved transplant Facility.

Coverage is provided for related cancer drug therapy pursuant to Section 8.28 of this Benefit Document.

**NOTE:** For a Preauthorized transplant, Coverage includes the necessary hospital, surgical, lab and X-ray services for a non-member donor, unless the non-member donor has coverage for such
services.

Level 1 - Covered in full
Level 2 - Covered in full for emergency admission only
    - Not covered for non-emergent admissions
Level 3 - Covered for emergency admission only
    - Not covered for non-emergent admissions

Exclusions include but are not limited to:

- All services for a Member donor to a non-Member recipient; and
- Community wide searches for a donor.

8.21 Reconstructive Surgery

Definition: Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance. Reconstructive surgery 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) for females.
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Service under this Benefit Document, disease, accidental injury, burns and/or severe inflammation.

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

Level 1 - Covered in full
Level 2 - Covered in full for emergency admission only
    - Not covered for non-emergent admissions
Level 3 - Covered in full for emergency admission only
    - Not covered for non-emergent admissions
    - Member is responsible for any amount in excess of Approved Amount

8.22 Oral Surgery

Oral surgery and X-rays are covered only when BCN Preauthorizes them for:

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw.
- Dental anesthesia in an outpatient setting when Medically Necessary and approved by BCN.
YOUR BENEFITS

- Medically necessary surgery for removing tumors and cysts within the mouth.

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

- Oral surgery and dental services necessary for immediate repair of trauma to the jaw, natural teeth, cheeks, lips, tongue and roof and floor of the mouth. NOTE: “Immediate” means treatment within 72 hours of the injury. Any follow-up treatment performed after the first 72 hours post-injury is not covered.

Coverage:

Level 1 - $20 Copayment for each office visit
Level 2 - $20 Copayment for each office visit
Level 3 - $20 Copayment for each office visit

  - Member is responsible for Copayment and any amount in excess of Approved Amount

NOTE: Dental services are not covered. See Section 9 for additional exclusions.

8.23 Temporomandibular Joint Syndrome (TMJ) Treatment

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

Coverage: 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;
- Specialty referral for medical evaluation and treatment;
- X-rays of the temporomandibular joint, including contrast studies; and
- Surgery to the temporomandibular joint including, but not limited to condylectomy, meniscectomy, arthrotomy and arthrocentesis.

Level 1 - $20 Copayment for each office visit
Level 2 - $20 Copayment for each office visit
Level 3 - $20 Copayment for each office visit

  - Member is responsible for Copayment and any amount in excess of Approved Amount

IMPORTANT: Dental services are not covered. See Section 9 for additional exclusions

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

8.24 Orthognathic Surgery

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

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

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

Coverage:

Level 1 - $20 Copayment for each office visit
Level 2 - $20 Copayment for each office visit
Level 3 - $20 Copayment for each office visit

• Member is responsible for Copayment and any amount in excess of Approved Amount

Exclusions include but are not limited to:

• Dental or orthodontic treatment including braces, prosthesis and appliances for or related to treatment for orthognathic conditions.

8.25 Weight Reduction Procedures

Surgery and procedures for weight reduction are covered when all of the following conditions are met:

• The BCN medical criteria and established guidelines related to the procedure; and
• The procedure is Preauthorized BCN as Medically Necessary.

Surgery is performed by the University of Michigan Health System.

Coverage:

Level 1 - $1,000 Copayment or 50% whichever is less for all fees associated with weight reduction procedures, including related facility and professional services
Level 2 - Not covered
YOUR BENEFITS

Level 3 - Not covered

**Exclusions include but are not limited to:** Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary as determined by BCN

### 8.26 Transgender Surgery

Transgender Surgery, also known as transgender transition services, involves the changing to a different sex (gender) through a surgical alteration to the genital area of the body. These procedures are typically done only after thorough evaluation and confirmed diagnosis of gender identity disorder. All services require Preauthorization by BCN. Covered Services are limited to:

- Surgical reconstructive procedures of the genitals, also known are sexual reassignment surgery;
- Breast reduction and chest reconstruction for reassignment from female to male;
- Genital electrolysis or laser hair removal for reassignment from male to female only; and
- Mental health support services consistent with an authorized gender assignment treatment plan.

**Coverage:**

- Level 1 - Covered in full
- Level 2 - Not covered
- Level 3 - Not covered

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

- Reversal of transgender surgical procedures; and
- Cosmetic procedures involving the face, breasts, abdomen, hips and other non-genital areas; including speech-language therapy, vocal cord procedures; electrolysis; and breast surgeries for male to female, unless as stated otherwise in Section 9.

### 8.27 Hearing Aids

**Coverage:**

- One (1) hearing evaluation test by a Plan Physician to determine if a hearing problem exists.
- When authorized by a Plan Physician an audiometric examination and hearing aid evaluation test to determine hearing acuity and the specific type or brand of hearing aid needed.
- Services provided for the fitting of a hearing aid and follow-up services to evaluate performance of the hearing aid and its conformance to the prescription.

**Limitations:**

- All services and hearing aids must be Preauthorized by BCN;
- You must obtain the hearing aid from a BCN-approved supplier;
- The hearing aid must be prescribed by Level 1 or Level 2 physician;
YOUR BENEFITS

- Hearing aids must be unilateral, binaural or the in-the-ear, behind the ear or on-the-body type. Eye-glass type hearing aids or other special features, to the extent the charge for such hearing aids or features exceed that for a covered hearing aid, are not a benefit; and
- Benefits for audiometric examination, hearing aid evaluation test and hearing aid are available only after 36 months have elapsed since the previous examination, test or aid provided under this Benefit Document.

Coverage:
Level 1 - $20 Copayment for each office visit
Level 2 - $20 Copayment for each office visit
Level 3 - $20 Copayment for each office visit
- Member is responsible for Copayment and any amount in excess of Approved Amount

Exclusions include but are not limited to:
- Replacement of hearing aids that are lost or broken and replacement parts and repairs are not a benefit unless at the time of such replacement you are eligible for an aid under the frequency limitations of this Benefit Document;
- Replacement batteries; and
- Medical or surgical treatment or drugs and medications relating to hearing problems.

8.28 Prescription Drugs and Supplies
A. Prescription Drugs Received while you are an Inpatient
We cover prescription drugs and supplies that are prescribed and received during a covered Inpatient Hospital stay as medical benefits.

B. Cancer Drug Therapy
We cover cancer drug therapy and the cost of administration. The 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.

Medically Necessary Cancer Drug Therapy when covered under this Benefit Document – Covered in full.
YOUR BENEFITS

Cost of administration – Covered in full.

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

C. Injectable Drugs
The following drugs are covered as medical benefits.
- Injectable and infusible drugs administered in a Facility setting; and
- Injectable and infusible drugs requiring administration by a health professional in a medical office, home or Outpatient Facility.

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

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

D. Outpatient Prescription Drugs
We do not cover prescription drugs and supplies unless you have a BCNSC Prescription Drug Amendment attached to this Benefit Document. (See Section 9)
Note: See Preventive Services Section for a list of preventive drugs that are covered when prescribed by a Participating Provider and dispensed by a Participating Pharmacy.

8.29 Clinical Trials

Definitions:
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 Federal Drug Administration;
- 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 Food and Drug Administration (FDA) when there are any remaining unanswered questions about a drug, device or treatment.

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

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

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

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

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

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

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

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

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

**Limitations and exclusions include but are not limited to:**

- The Experimental or Investigational item, device or Service itself;
- Experimental treatment or Services related to Experimental treatment, except as explained under “Coverage” above;
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Administrative costs related to Experimental treatment or for research management; or
- Coverage for Services not otherwise covered under this Benefit Document.
- Drugs or devices provided to you during a BCN approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the Member’s condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.
- Complications resulting from an Experimental procedure.
Section 9: Exclusions and Limitations

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

9.1 Facility Admission Prior to Effective Date

If you must be admitted to a hospital, skilled nursing or residential substance abuse/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.

9.2 Services That Are Not Medically Necessary

Services that are not Medically Necessary are not covered unless specified in this Benefit Document. The Medical Director makes the final determination of Medical Necessity.

9.3 Non covered Services

Coverage does not include the following services:

- Services that do not meet the terms and guidelines of this Benefit Document.
- Private duty nursing.
- Services provided or performed by a Chiropractor.
- Male mastectomy for treatment of gynecomastia.
- Cognitive services including but not limited to those pertaining to perception, attention, memory or judgment. Examples include but are not limited to, 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.)

9.4 Cosmetic Surgery

Cosmetic surgery is surgery done primarily to improve appearance and/or self-esteem. We do not cover cosmetic surgery or any of the related services, such as pre-or post-surgical care, follow-up care, or reversal or revision of the surgery.

9.5 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 as defined in Section 8 under this Benefit Document.
9.6 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.

9.7 Custodial Care
There is no coverage for Custodial Care, i.e., 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.

9.8 Comfort and Convenience Items
Personal or comfort items, such as telephone, television, etc are not covered. (See Section 8 for Durable Medical Equipment exclusions.)

9.9 Mental Health/Substance Abuse
- We do not cover psychoanalysis and open-ended psychotherapy.
- We do not cover custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include ¾ house or ½ way house placement, room and board, health care aids, and personal care designed to help in activities of daily living or to keep from continuing unhealthy activities.
- We do not cover maintenance treatments for opiate addiction.
- Treatment of Chronic illnesses is limited to:
  - Treatment that is Medically Necessary to prevent an Acute episode of Chronic illness, or
  - Treatment of Acute exacerbation of Chronic illness (any level of care, subject to other exclusion).
- We do not cover 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 are not covered benefits.
- We do not cover court ordered examinations, test, reports or treatments that do not meet requirements for Mental Health or Substance Abuse coverage.
- We do not cover marital counseling services.

9.10 Court Related Services
- There is no coverage for pretrial and court testimony, a court-ordered exam, or the preparation of court-related reports that does not meet Coverage requirements.
- There is no coverage for court-ordered treatment for substance abuse or mental illness except as specified in Sections 8.
- Services related to your convicted commission of a crime or participation in an illegal activity.
YOUR BENEFITS

- Services rendered while you are in the custody of law enforcement.

9.11 Elective Procedures
The following elective procedures are not covered:
- Reversal of surgical sterilization.
- Reversal of transgender transition services.
- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT-zygote intrafallopian transfer and all related services.
- Artificial insemination All services related to surrogate parenting arrangements, including, but not limited to, maternity and obstetrical care for non-member surrogate parents.
- Services and supplies provided by a lay-midwife and home births.
- Infertility treatment including prescription drugs except for the diagnosis of infertility as described in this document.

9.12 Dental Services
There is no Coverage for dental services, dental prostheses, restoration or replacement of teeth, X-rays, oral surgery or anesthesia for dental procedures even if related to a medical condition or treatment except as specifically stated in Section 8.

9.13 Services Covered Through Other Programs
There is no Coverage for any services that are available to you under the following circumstances:
- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or benefit document.
- Under any other policy, program, contract or insurance as stated in Chapter 1, General Provisions, Section 3, ‘Other Party Liability.’ (General Provisions is the chapter of this booklet that describes the rules of your Coverage.)
- Under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, except where your Coverage is required by law to be your primary Coverage.
- Under any contractual, employment or private arrangement (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or hospital services.
- Emergency Services paid by foreign government public health programs.
- Any services whose costs are covered by third parties (including but not limited to, employer paid services such as travel inoculations and services paid for by research sponsors.

9.14 Alternate Services
Any alternative service (a treatment not traditionally being used in standard Western medicine, and is not widely taught in medical schools), such as acupuncture, herbal treatments, massage
therapy, therapeutic touch, aroma-therapy, naturopathic medicine (herbs and plants), homeopathy, and traditional Chinese medicine is not covered.

9.15 Vision Services
The following vision services or items are not covered:

- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Glasses, frames and contact lenses except as specified in Section 8.
- Dilation
Customer Service
800-658-8878
TTY for the hearing impaired: 800-649-3777
8:00 a.m. to 5:30 p.m. Monday through Friday

Please address inquiries to:
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