U-M PREMIER CARE

Benefit Document

M Premier Care

Blue Cross
Blue Shield
Blue Care Network
of Michigan

U-M PREMIER CARE
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, Group Health Plan and Blue.

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

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").

BCN SC 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.

This Benefit Document describes the benefits provided under your Coverage in accordance with the Administrative Services Contract ("ASC").

By choosing to enroll as a BCNSC Member, you, the Member, agree to abide by the rules as stated in the General Provisions and Your Benefits chapters. 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.benefits.umich.edu. The University of Michigan Benefits Office reserves the right to interpret and resolve conflicts between any statements in this U-M Premier Care 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 BCN SC nor its subcontractors, including BCN are responsible for insuring coverage for your benefits under the U-M Premier Care Plan.

If you have questions about this Coverage, contact University of Michigan Benefits Office or BCN Customer Service Department.

Blue Care Network
20500 Civic Center Drive
Southfield, MI 48076
800-662-6667
bcbsm.com

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 and 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.

Coinsurance is your share of the costs of a Covered Service calculated as a percentage of the Approved Amount that you owe after you pay any Deductible. This amount is determined based on the Approved Amount at the time the claims are processed. Your Coinsurance is not altered by an audit, adjustment or recovery. Your Coinsurance is added or amended when a Rider is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

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

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 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.

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

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

Custodial Care is care primarily used to help the patient with activities of daily living or meeting personal needs. Such care includes help with walking, getting in and out of bed, bathing, cooking, cleaning, dressing and taking medicine. Custodial Care is not a covered benefit.

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

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, freestanding 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.

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 Use Disorder, psychiatric disorders or pulmonary tuberculosis.

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

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

Medical Episode is an acute incidence of illness or symptoms, 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 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 Use Disorders

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

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

Non-Participating or Non-Participating Provider means an individual provider, Facility, or other health care entity, which is employed neither by nor 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 BCN. 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.

Out-of-Pocket Maximum is the most you have to pay for Covered Services during a Calendar Year. The Out-of-Pocket Maximum includes your medical Deductible, Copayment and Coinsurance. This limit never includes your premium, Balance Billed charges or health care services that BCN does not cover. (See Section 8.1)

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 Copayments or Deductible if applicable.

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

PCP Referral is the process by which the Primary Care Physician directs you to a Referral Physician prior to a specified service or treatment plan. The PCP coordinates the Referral and any necessary BCN authorization. For example, in order to receive a Covered Service from a Network 1 specialist or Network 2 provider, a Referral is required from your PCP.

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.

Preventive Care is care designed to maintain health and prevent disease. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

Primary Care Physician (PCP) is a Participating Provider in the U-M Premier Care Provider Network 1 who you choose to provide or coordinate all of your medical health care, including specialty and Hospital care. The Primary Care Physician is licensed in the State of Michigan in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

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

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

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

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

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

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

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

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

U-M Premier Care Provider Network 1 is the preferred network of individuals, facilities, or other health care entities, as defined by the University of Michigan where you will receive the highest level of benefit.

U-M Premier Care Provider Network 2 is the BCN statewide participating provider network made up of individuals, facilities, and other health care entities that are not part of the U-M Premier Care Provider Network 1. In order to access a covered service from Provider Network 2, a referral is necessary from your Primary Care Physician. These services are subject to Deductible. (Deductible does not apply to Preventive Services. Please refer to Preventive and Early Detection Service section for additional information.)

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.

Table of Contents

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. BCNS 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 U-M Premier Care 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 eligible. Except as otherwise provided by applicable law, benefits for individuals 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, U-M Premier Care Plan 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 Premier Care Provider Network 1 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 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 Preauthorized 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 BCNSC ID Card.

A family dependent must notify BCN before receiving any services from a non-Contracted provider that require Preauthorization. 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 1 area for less than three (3) months
- Individuals who misrepresent that they are residing outside of the Premier Care Provider Network 1 area
- Family dependents who are not residents of the United States (or the portion of Canada within 50 miles of the Premier Care Network 1 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 Preauthorized 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 Non duplication

- BCNSC Coverage provides you with benefits for health care services as described in this Benefit Document.
- BCNSC does not duplicate benefits or pay more for Covered 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 and Auto Policy Claims

Benefits under this Benefit Document exclude services and treatment for any work related injury to the extent that benefits are paid or payable under any worker's compensation program or other similar program. Where services are provided by Group Health Plan, Group Health Plan is assigned the Member's right 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 non-coordinated no-fault automobile policy; the health plan will assume primary liability to provide benefits available under this Benefit Document in accordance with this Benefit Document's terms and conditions.

2.3 Coordination of Benefits (COB)

We coordinate Benefits payable under this Benefit Document per the National Association of Insurance Commissioners (NAIC) guidelines.

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.

2.4 Subrogation and Reimbursement

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

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

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

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

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

"**Common Fund Doctrine**" is a legal doctrine that requires BCNSC to reduce the amount

received through subrogation by a pro rata share of the plaintiff's court costs and attorney fees.

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

- Judgment or settlement of a legal action
- Settlement not due to legal action
- 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 may select a Primary Care Physician from the list of participating U-M Premier Care Provider Network 1 physicians who is available to accept you or your family members. If you do not choose a Primary Care Physician upon enrollment, we will choose a Primary Care Physician for you.

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

You do not need prior authorization from BCN or from any other person, including your Primary Care Physician, in order to obtain access to obstetrical or gynecological care from a Participating U-M Premier Care Network 1 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 U-M Premier Care Provider Network 1 Primary Care Physician.

For information on how to select a Primary Care Physician, and for a list of U-M Premier Care Provider Network 1 Participating Primary Care Physicians, Participating pediatricians and Participating health care professionals who specialize in obstetrics and gynecology contact

Customer Service at 1-800-658-8878 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
- 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.
- Determine whether a provider is a U-M Premier Care Network 1 Participating Provider before obtaining services.

Section 4: Forms, Identification Cards, Records and Claims

4.1 Forms and Enrollment

You must complete and submit any enrollment form, or other forms that, as applicable, the 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 at the number provided on the back of your ID card.

4.2 Identification Card

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

To be entitled to 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 Copayments 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, is available at bcbsm.com and 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 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 BCNSC 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 at 1-800-658-8878 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 discharged;
- Your Benefits exhausted prior to the end of the contract; or
- You become eligible for other coverage.

NOTE: If Coverage is rescinded due to fraud or intentional misrepresentation of material fact, this extension shall not apply.

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.

If your employer is required by COBRA to offer you the option of purchasing continuation coverage, you will need to be aware of the following conditions:

1. You may apply and pay for group continuation coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
2. This coverage may continue for up to 18, 29 or 36 months, depending on the reason for your initial ineligibility.
    - You are considered a Group Member for all purposes, including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
    - Continuation coverage and all benefits cease automatically under any of the following:
        - The period allowed by law expires.
        - The employer no longer includes BCNSC Coverage as a part of its Group Health.
        - You begin coverage under any other benefit program or health coverage plan (with some exceptions).
        - After electing COBRA continuation coverage, you become eligible for Medicare.
        - You do not pay for Coverage fully and on time.

Section 7: General Provisions

7.1 Notice

Any notice that BCNSC is required to give to you will be:

- In writing
- Delivered personally or sent by U.S. Mail
- 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 eight (8) months out of each Calendar Year. See Section 1.1.

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, Copayments, 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; and
- 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;
- 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 BCN 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 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 BCN to process claims incurred in other states through the Host Plan, subject to Blue Cross® and Blue Shield® Association policies.

Designated Payment Level is the amount used to calculate your BCN Copayment under the BlueCard Program is 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 the Emergency Services section in Chapter 2 of this Benefit Document.

What You Must Pay

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

This Benefit Document provides you with important information about your health care Benefits including Preauthorization requirements. Any attached Amendment(s) provides you with additional information about your Cost Sharing and Benefit Maximums when you receive health care Services. Read the entire Benefit Document and all attached Amendments carefully.

- 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 Preauthorizations for services.
- The services listed in this chapter are covered when services are provided in accordance with Coverage and, when required, are Preauthorized or approved by BCN.
- 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 this chapter.
- If you receive a service that we do not cover, you will be required to pay for that service.
- You are responsible to determine whether a provider participates in U-M Premier Care Provider Network 1 or U-M Provider Network 2 before obtaining services.
- You are responsible for Copayments for many of the benefits listed. You may also be responsible for a Deductible if you receive services from a Network 2 provider.
- If a deluxe item or equipment is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the Member's option. You are responsible for any costs over the Approved Amount designated by BCN.
- 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 any 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.
- For a list of Services that require Preauthorization, contact Customer Service at the number provided on the back of your BCNSC ID card.
- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.

8.1 U-M Premier Care Provider Network 1 and Network 2 Cost Sharing

U-M Premier Care Provider Network 1

When you receive services in the U-M Premier Care Provider Network 1, you will be responsible for applicable Copayments, but you are not responsible for payment of Deductibles.

NOTE: You are responsible for determining whether a provider is a Participating Provider before obtaining services. This information can be found at bcbsm.com or by contacting Customer Service at the number provided on the back of your ID card. Unless otherwise specified in this Benefit Document, Benefits will be paid based on the status of the provider as of the day the services are received.

U-M Premier Care Provider Network 2

When you receive services in the U-M Premier Care Provider Network 2, you will be responsible for payment of Deductibles as described below.

NOTE: Services received from U-M Premier Care Provider Network 2 must be referred by your Primary Care Physician and authorized by BCN. Your Network 2 benefits will apply.

Copayment

You are responsible for set dollar amount **Copayments** or ("Copays") for many of the benefits listed in this Benefit Document. You will need to pay any Copayments at the time you receive the services.

Deductible

Deductible is the amount you pay before BCNSC will pay for Covered Services provided by a Network 2 provider. The Deductible renews each Calendar Year. Any Deductible paid during the last three months of the Calendar Year will be carried over into the new Calendar Year.

Deductible for U-M Premier Care Provider Network 1:

You pay no Deductible for the services you receive from this network.

Deductible for U-M Premier Care Provider Network 2:

Covered Services received from Network 2 providers are subject to a Deductible.
Applicable Deductibles per Calendar Year are:

DEDUCTIBLE U-M Premier Care Provider Network 2	
$2,000 per Member	$4,000 per family (when two or more are covered under one contract

In the case of two or more Members in a family contract, the Deductible paid by all Members will be combined to satisfy the family Deductible. However, one individual Member cannot contribute in excess of the per Member Deductible toward the Family Deductible. Once an individual Member meets the per Member Deductible, they will not be responsible for any

additional Deductible for the remainder of the Calendar Year.

BCNSC Approved Amount will be applied to the Deductible for Covered Services. Charges paid by you in excess of the BCNSC Approved Amount do not apply toward the Deductible.

U-M Premier Care Provider Network 2 Deductible Exceptions:

Some services are not subject to the Deductible. Those services are:

- Preventive and early detection services:
- Emergency services;
- Ambulance services;
- Laboratory and pathology testing;
- Routine vision exam;
- Durable medical equipment;
- Prosthetics and orthotics; and
- Prescription drug therapy

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 U-M Premier Care Provider Network 1 and U-M Premier Care Provider Network 2 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.

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

NOTE: Your prescription drug coverage is administered through a separate pharmacy benefit manager not affiliated with BCNSC. As a result, the Out-of-Pocket Maximum amount defined above includes medical Cost Sharing only. It does not include prescription drug coverage Cost Sharing.

You have a separate Out-of-Pocket Maximum amount for prescription drug coverage Cost Sharing as defined by your Group. The medical and prescription drug coverage Out-of-

Pocket Maximum does not exceed the maximum limit set annually by the Center for Medicare and Medicaid Services.

OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR	
$3,000 per Member	$6,000 per Family

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

a) **Office Visits** - provided by your Primary Care Physician or a Referral Physician when services are rendered in an outpatient office site including visits at hospital locations

Primary Care Physician and Pediatrics	
U-M Premier Care Provider Network 1	$25 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

Referral Physician	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

b) **Maternity Care** - including prenatal and postnatal visits provided by your Primary Care Physician or Participating OB/GYN.

Maternity Care	
U-M Premier Care Provider Network 1	Prenatal and postpartum visits are covered in full
U-M Premier Care Provider Network 2	Prenatal visits are covered in full. Postpartum visits: • Require a Referral from Provider Network 1; and • Deductible applies.

c) **Home Visits** - provided by a physician in the home or temporary residence. For additional home health care services, other than physician visit, please refer to the Home Health Care Services section in this chapter.

Home Visits	
U-M Premier Care Provider Network 1	Covered in full

U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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.

Inpatient Professional Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

Allergy Care	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit may apply • Injections are covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

8.3 Continuity of Care for Professional Services

Continuity of Care for Existing Members

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

Physician Requirements

The Continuity of Care provisions apply only when 1) your physician notifies 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 (typically six weeks) for Covered Services directly related to your pregnancy.

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

Coverage

If the former Participating Provider (including your Primary Care Physician) provides notification to you and agrees to meet the "Physician Requirements" listed above, 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 Hospital facility services are covered when Medically Necessary and Preauthorized by your PCP and BCN, unless they are listed elsewhere in this Benefit Document with a specific Copayment.

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

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

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

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

- Newborn care

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

  - 48 hours following a vaginal delivery

– 96 hours following a delivery by cesarean section

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

The baby must be eligible for Coverage and must be added to your contract as stated in Section 1.

Coverage

Inpatient Hospital Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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 Services

Outpatient Services (Facility and professional) when performed in an Outpatient Hospital setting, physician office, free standing center, or dialysis center for the diagnosis or treatment of a disease, injury or other medical condition are covered when Medically Necessary and Preauthorized by your treating physician and BCN.

Outpatient Services include but are not limited to:

- Surgical treatment
- Anesthesia, laboratory, radiology and pathology Services
- Chemotherapy, inhalation therapy, radiation therapy and dialysis
- Physical, speech and occupational therapy - see Outpatient Therapy Services
- Injections (for allergy) - see Professional Physician Services (Other Than Mental Health and Substance Use Disorder)
- Professional Services - see Professional Physician Services (Other Than Mental Health and Substance Use Disorder)
- Durable medical equipment and supplies - see Durable Medical Equipment
- Diabetic equipment and supplies - see Durable Medical Equipment
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics
- Other Outpatient Services and supplies necessary for the treatment of the Member

Coverage

Outpatient Hospital Services	
U-M Premier Care Provider Network 1	Covered in full

U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies
U-M Premier Care Provider Network 2 Deductible does not apply to laboratory and pathology services.	

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 worsen if not treated within 24 hours. Examples include: flu, strep throat, or other infections; foreign material in the eye, sprain or pain following a fall; and a cut, sore or burn that does not heal.

Coverage

Emergency 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 because 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 the 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.

U-M Premier Care Provider Network 1 and U-M Premier Care Provider Network 2

Coverage

Emergency Services provided in a Hospital Setting	
U-M Premier Care Provider Network 1	$100 Copayment
U-M Premier Care Provider Network 2	$100 Copayment • Deductible does not apply
If you are admitted as an Inpatient as a result of the emergency, your emergency Copayment is waived.	

Emergency Services provided in an Urgent Care Center	
U-M Premier Care Provider Network 1	$25 Copayment
U-M Premier Care Provider Network 2	$25 Copayment

Emergency Services at a Non-Participating Hospital

If you are hospitalized in a Non-Participating Facility, we may require that you be transferred to an affiliated hospital as soon as you are stabilized.

Out-of Area Coverage

You are covered when traveling outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above. We will pay the greater of the median in-network rate, the usual, customary and reasonable rate or the Medicare rate. You are responsible for any Cost Sharing required.

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

– When transport is ordered by the attending physician and the following conditions are met:
  - The use of an air ambulance is medically necessary.
  - No other means of transport is available, or the Member's condition requires transport by air rather than ground ambulance.
  - An air ambulance provider is licensed as an air ambulance service and is not a

commercial airline.

- The Member is transported to the nearest facility capable of treating the Member's condition. The facility must be:
  - The nearest facility, or
  - Another appropriate facility within a reasonable distance of the nearest available facility.
  - BCN will determine whether a facility is appropriate and what a reasonable distance is

- **Emergency ground ambulance** services when:
  - You are admitted as an inpatient to the hospital immediately following emergency room treatment.
  - The services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management.
  - The services are needed for emergency delivery and care of a newborn and mother. (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: U-M Premier Care Provider Network 2 Deductibles do not apply to Ambulance Services.

Exclusions include but are not limited to

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

8.8 Preventive and Early Detection Services

a) **Preventive Services and Early Detection Services** received in U-M Premier Care Provider Network 1 and U-M Premier Care Provider Network 2

There is no Copayment, Coinsurance and/or Deductible (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.

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 covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. Convenience items such as storage containers, bags, bottles and nipples are not covered. (See Durable Medical Equipment section for limitations and exclusions)
  - Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening;
  - Screening for gestational diabetes;
  - Bone density screening;
  - Genetic counseling and BRCA testing, if appropriate, for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes;
  - Screening and counseling for interpersonal and domestic violence; and
  - Female sterilization services

- **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 BCNSC. 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 and diet behavioral counseling;

  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 BCNSC 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: Cost Sharing will apply to non-routine diagnostic procedures. If this Benefit Document is amended by Deductible, Copay and/or Coinsurance Amendments, the attached Amendments will take precedence over this Benefit Document for non-preventive services. 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.

To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to www.uspreventiveservicestaskforce.org. You may also contact 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

Routine Vision Exam	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2 and Non Participating Optometry	• Covered up to $40.00 per Member per Calendar Year;

Providers	• Deductible does not apply to routine vision exams.
Limited to one routine vision exam per Member per Calendar Year	

Exclusions include but are not limited to

Dilation, frames, lenses, contact lenses and fittings

8.9 Reproductive Care and Family Planning Services

This benefit includes:

- Infertility
- Voluntary Sterilization
- Termination of pregnancy
- Genetic testing

a) Infertility with In-Vitro Fertilization

Coverage of infertility includes **diagnostic evaluation, assessment, 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.

Infertility	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

In-vitro fertilization (IVF) procedures, and all related services including drugs administered by the physician in the physician's office are covered as follows:

- For females diagnosed with infertility when determined to meet the criteria defined by the University of Michigan and BCN, and Preauthorized by BCN;

- For male/female couples who are unable to conceive after engaging in regular unprotected intercourse for a defined period of time or the inability to sustain a pregnancy;
  - For females under the age of 35, the time frame is 12 months of unprotected intercourse;
  - For females over age 35, the time frame is 6 months.

- Coverage for females without documented infertility who do not have the exposure to sperm requires a minimum of 12 donor sperm intrauterine insemination (IUI) cycles for females under age 35; and 6 donor sperm cycles for females age 35 and older that do not result in live birth, The IUI cycles must be supervised by a physician or an appropriate licensed practitioner.

All IVF services must be provided through the University of Michigan Health System Center for Reproductive Medicine.

Limitations

In-vitro benefit limitations include:

- Single embryo transfer available for women through age 35;
- Double embryo transfer available for women 35 through the age of 42
- IVF service not covered for women over the age of 42;
- Embryo freezing and storage up to one year for each cycle for Members in active infertility treatment; and
- Non-office administered infertility drugs and delivery (such as pumps) covered only through University of Michigan pharmacy benefit manager.

Coverage

In-Vitro Fertilization	
U-M Premier Care Provider Network 1 Services must be rendered by the University of Michigan Health System; Center for Reproductive Medicine.	Covered 80%; 20% Coinsurance for all IVF procedures, professional services and related services The 20% Coinsurance applies to the Out-of-Pocket Maximum. Covered infertility services are subject to a Lifetime Maximum of $20,000 per female Member. Once the Lifetime Maximum has been reached, infertility services are no longer covered under this Benefit Document. NOTE: Diagnostic work-up, ultrasounds, counseling and labs already covered are excluded from the lifetime maximum.
U-M Premier Care Provider Network 2	Not a covered benefit

Exclusions include but are not limited to

- Intrauterine insemination (IUI);
- Egg harvesting or other infertility treatment performed during an operation not related to an infertility diagnosis;
- Voluntary female sterilization ends coverage for IVF;
- Coverage for a Member who is not medically infertile;
- Storage or manipulation of eggs and sperm except as noted above;

- 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;
- Donor eggs and donor sperm
- All services related to surrogate parenting arrangements, including but not limited to In-Vitro services and 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.

Coverage

Male Sterilization Services	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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.

Coverage

Termination of Pregnancy	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

Coverage

Genetic Testing	
U-M Premier Care Provider Network 1	$30 Copayment for each office visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1

	• Deductible applies

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

Exclusions include but are not limited to

Genetic testing and counseling for non-Members

8.10 Skilled Nursing Facility Services

Skilled Nursing Facility Services are covered 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

Skilled Nursing Facility Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies
Covered up to a total cumulative maximum of 120 benefit days per Calendar Year - The benefit days under U-M Premier Network 1 and U-M Premier Network 2 are cumulative. For example, use of a benefit day under U-M Premier Network 1 Coverage will reduce the benefit days available under both the U-M Premier Network 1 and U-M Premier Network 2 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
- Custodial Care

8.11 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 are covered when they are Medically Necessary. Home care services include:

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy

  NOTE: Outpatient therapy limits as defined in the Outpatient Therapy Services section do not apply.
- Hospice Care
- Other health care services approved by BCNSC when they are performed in the Member's home

Coverage

Home Health Care Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

Exclusions include but are not limited to

- Housekeeping services
- Custodial Care

8.12 Hospice Care

Definition

Hospice Care is an alternative form of medical care for terminally ill Members with a life expectancy of 6 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
- 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

Hospice Care	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

Exclusions include but are not limited to

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

delivering Custodial Care

8.13 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 nursing home).

Food Supplements

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

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

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

Coverage

Home Infusion Therapy Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

8.14 Mental Health Care

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 that are Medically Necessary or to those Outpatient Services needed to prevent an Acute episode of a Chronic illness.
- Medical services required during a period of mental health admission must be authorized

separately by 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.
- **Residential Mental Health Treatment** is treatment that takes place in a licensed mental health facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential treatment is:
  - Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
  - A structured environment that will allow the individual to successfully reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the Member's usual living environment; and
  - Not based on a preset number of days such as standardized program (i.e. "30-Day Treatment Program"), however, the benefit design will be the same as your medical inpatient benefit when Preauthorized by BCN.

Coverage

Mental health care is covered in a variety of settings. You may be treated in an Inpatient or in an Outpatient setting.

To obtain services call BCN Behavioral Health Management at the number provided on the back of your ID card. They are available 24 hours a day, 7 days a week.

Outpatient Mental Health/Intensive Outpatient Mental Health	
U-M Premier Care Provider Network 1	$25 Copayment per visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider

	Network 1 • Deductible applies

Inpatient Mental Health/Residential Treatment/Partial Hospitalization	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

NOTE: See Section 9 for Exclusions and Limitations.

8.15 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 Disorder. AAEC evaluation is necessary for ABA.

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

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

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

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 ASD covered under this Benefit Document.

Benefits

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

- Comprehensive treatment focused on managing and improving the symptoms directly related to a Member's ASD.
- Therapeutic care as recommended in the treatment plan includes:
  - Occupational therapy, speech and language therapy and physical therapy (when performed by a Participating occupational therapist, Participating speech therapist and Participating physical therapist);
  - ABA (when performed by a Participating BCBA and Participating psychologist);
  - Outpatient mental health therapy (when performed by a Participating social worker, Participating clinical psychologist and Participating psychiatrist);
  - Social skills training
  - 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 AAEC 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

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

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

ABA for Line Therapy services is subject to Network 1 and Network 2 Primary Care Physician Cost Sharing 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 Network 1 and Network 2 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.

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 ASD.

Limitations

Coverage is available subject to the following requirements:

- **Prior Authorization – Network 1 and Network 2** services performed under the recommended Treatment Plan must be approved for payment during BCN's Preauthorization Process. If Preauthorization is not obtained, rendered services will not be covered and the Member may be held responsible for payment for those services.

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

- **Providers** – To receive lower out of pocket costs, Network 1 and Network 2 services to treat ASD must be performed by a BCN approved provider. All services to treat ASD 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 BCNSC Approved Amount.

- **Required Diagnosis for ABA** – The Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, Participating developmental pediatrician or other professional as agreed upon by a BCN AAEC in order to receive Preauthorization for ABA. Other authorization requirements may also apply. The requirement to be evaluated and diagnosed by a BCN AAEC does not exist for other services related to ASD.

- **Termination at age 19** – Benefits are limited to Members up to and including the age of 18. This age limitation does not apply to outpatient mental health services (excluding ABA services) and services used to diagnose ASD. Benefits for ASD terminate on the Member's 19th birthday.

- **Treatment Plan** – Network 1 and Network 2 services must be included in a Treatment Plan recommended by a BCN AAEC that evaluated and diagnosed the Member's condition.

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

Exclusions

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

8.16 Substance Use Disorder Services/Chemical Dependency

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

All Substance Use Disorder/Chemical Dependency treatments must be 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 illnesses that are Medically Necessary or to those Outpatient Services needed to prevent an Acute episode of a Chronic illness.
- Medical inpatient services required during a period of Substance Use Disorder admission must be authorized separately by your PCP or by BCN.

Definitions

- **Detoxification (Detox)** means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detox can occur in an inpatient, outpatient or residential setting.
- **Domiciliary Partial** refers to partial hospitalization combined with an unsupervised overnight stay (Residential) component.
- **Intensive Outpatient Substance Use 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 Use services that have a residential (overnight) component. Intermediate Care includes Detox, domiciliary partial and residential (including "inpatient" and "rehab") services.

- **Outpatient Substance Use Disorder 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, Detox, medical testing, diagnostic evaluation and referral for other services.
- **Partial Hospitalization/Domiciliary Partial** is a comprehensive, acute care program that consists of a minimum of 6 hours per day, 5 days a week. Partial Hospitalization treatment may include, but is not necessarily limited to counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.
- **Residential Substance Use Disorder Treatment** means Acute care services provided in a structured and secure 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, Detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Residential Substance Use Disorder Treatment is sometimes also referred to as inpatient Substance Use Disorder treatment or rehabilitation ("rehab").

Coverage

Substance Use Disorder services including counseling, medical testing, diagnostic evaluation and Detox are covered in a variety of settings. You may be treated in an Inpatient or in an Outpatient setting.

To obtain services call BCN Behavioral Health Management at the number provided on the back of your ID card. They are available 24 hours a day, 7 days a week.

Outpatient/Intensive Outpatient Substance Use Disorder Treatment	
U-M Premier Care Provider Network 1	$25 Copayment per visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

Detoxification/Residential/Intermediate Care/Partial Hospitalization	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

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
- 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 the 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 medical episode per Calendar Year for any combination of physical, occupational and speech therapy. Treatment for conditions considered to have a minor diagnosis is limited to 15 visits per medical episode per Calendar Year for any combination of physical, occupational and speech therapy. Major and minor diagnoses are determined by the Group Health Plan.

Coverage

Outpatient Rehabilitation	
U-M Premier Care Provider Network 1	$25 Copayment per session
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

NOTE: The benefit days under U-M Premier Network 1 and U-M Premier Network 2 are cumulative. For example, use of a benefit day under U-M Premier Network 1 Coverage will reduce the benefit days available under both the U-M Premier Network 1 and U-M Premier Network 2 Coverage.

General exclusions include but are not limited to

- Cognitive therapy and retraining (neurological training or retraining)
- Services that can be provided by an federal or state agency or local political subdivision, including school districts, when the Member is not liable for the costs in the absence of insurance
- Vocational rehabilitation
- Therapy to maintain current functional level and prevent further deterioration
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency

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
- 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 in an 18 week period per Medical Episode.

Cardiac Rehabilitation	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

NOTE: The benefit days under U-M Premier Network 1 and U-M Premier Network 2 are cumulative. For example, use of a benefit day under U-M Premier Network 1 Coverage will reduce the benefit days available under both the U-M Premier Network 1 and U-M Premier Network 2 Coverage.

Pulmonary Rehabilitation

Covered up to 1 program of 12 sessions per year per condition

Pulmonary Rehabilitation	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

NOTE: The benefit days under U-M Premier Network 1 and U-M Premier Network 2 are cumulative. For example, use of a benefit day under U-M Premier Network 1 Coverage will reduce the benefit days available under both the U-M Premier Network 1 and U-M Premier Network 2 Coverage.

8.18 Durable Medical Equipment and Diabetic Supplies Definitions

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

Durable Medical Equipment (DME) is equipment that must be used primarily for medical purposes and requires a prescription from the treating physician. 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.

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 Service at the number provided on the back of your ID card.

Durable Medical Equipment including Diabetic Supplies	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	Covered in full; Deductible does not apply • Requires a Referral from Provider Network 1

Limitations

- The equipment must be considered DME under your Coverage, and 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 the 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 Preventive and Early Detection Services section for additional information.)

Exclusions include but are not limited to

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the Member and required so the Member can operate the equipment; ; (NOTE: If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the Member's option. You are responsible for any costs over the Approved Amount for the deluxe item that may be prescribed.)
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bed boards, bathtub lifts, 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
- Needles and syringes for purposes other than the treatment of diabetes
- Alcohol and gauze pads
- 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
- All repairs and maintenance that result from misuse or abuse
- Any late fees or purchase fees if the rental equipment is not returned within the stipulated period of time

8.19 Orthotics and Prosthetics

Definitions

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

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

Prosthetic devices can be either:

- External 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.
- 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.

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 of Keratoconus
- Replacement lenses for infants & children is as follows:
  - If cataract removal surgery is performed on one eye, one contact lens initially following surgery, and an additional replacement lens each year until the child's fifth birthday.
  - If cataract removal surgery is performed on both eyes, two lenses will be covered initially, and two replacement lenses annually until the child reaches his/her fifth birthday.
  - Replacement of lenses due to growth and development

  Note: Replacement contact lenses are *not* covered under the medical plan beyond the child's fifth birthday. From that point, replacement contact lenses may be covered according to the terms of the Member's vision care amendment, if applicable
- 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.

Prosthetics and Orthotics	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Covered in full; Deductible does not apply • Requires a Referral from Provider Network 1

Limitations

The item must meet the following conditions.

- Meet the Coverage definition of a prosthetic or orthotic device.
- Preauthorized by BCN
- Obtained from a BCN-approved supplier

- Prescribed by your Primary Care Physician or a Participating Provider
- 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.
- 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
- 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
- Duplicate appliances and devices

8.20 Organ and Tissue Transplants

Organ or body tissue transplant and all related services are covered when

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

Donor Coverage for a BCNSC Recipient

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

Donor Coverage for a non-BCNSC Recipient

Member donor Cost Sharing may apply (as defined below) when Preauthorized if the recipient's health plan does not cover BCNSC Member donor charges.

Cost Sharing does apply (as defined below) if the recipient's coverage does not cover the BCNSC donor charges.

Exclusions include but are not limited to

- Community wide searches for a donor

Coverage

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

Organ and Tissue Transplants	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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 lymph edema
- Reduction mammoplasty (breast reduction surgery) 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 as defined above when it is Medically Necessary and Preauthorized by BCN.

Reconstructive Surgery	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

8.22 Oral Surgery

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

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

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw;
- Dental anesthesia in an outpatient setting when Medically Necessary and approved by BCN.
- 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. If services are received from U-M Premier Care Provider Network 2, Deductible will apply.
- 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

Oral Surgery	
U-M Premier Care Provider Network 1	$30 Copayment per visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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.

IMPORTANT: Dental services are not covered. (See Section 9.)

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.

TMJ Treatment	
U-M Premier Care Provider Network 1	$30 Copayment per visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1

	• Deductible applies

Exclusions include but are not limited to

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

8.24 Orthognathic Surgery

Definition

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

Coverage

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
- Hospitalization - only when it is Medically Necessary to perform the surgery in a hospital setting

Orthognathic Surgery	
U-M Premier Care Provider Network 1	$30 Copayment per visit
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

Weight Reduction procedures and surgery are covered when all of the following conditions are met.

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

Weight Reduction Procedures	
U-M Premier Care Provider Network 1	$1,000 Copayment, or 50% whichever is less, for all fees associated with

	weight reduction procedures, including related Facility and professional services.
U-M Premier Care Provider Network 2	Not a covered benefit

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.

Coverage

Covered Services are limited to:

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

Transgender Surgery	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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; speech-language therapy, vocal cord procedures; electrolysis; and breast surgeries for male to female, unless as stated otherwise in Section 8.

8.27 Hearing Services

Covered services include:

- 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

Hearing Services	
U-M Premier Care Provider Network 1	Covered in full
U-M Premier Care Provider Network 2	• Requires a Referral from Provider Network 1 • Deductible applies

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

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 U-M Premier Care Provider Network 1 or U-M Premier Care Provider Network 2 physician
- 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
- 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

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
- 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 treatment is Medically Necessary and Preauthorized by BCN
- The drug is ordered by a physician for the treatment of cancer

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

Cancer Drug Therapy - Covered in full

Cost of administration - Covered in full

Coordination of Benefits for cancer therapy drugs: If you have BCNSC Prescription Drug Amendment or coverage through another plan, your BCNSC Prescription Drug Amendment or your other plan will cover drugs for cancer therapy that are self administered first before Coverage under this Benefit Document.

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. BCN will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting.

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

Exclusions include but are not limited to

Drugs that are intended to be self-administered as defined by the FDA 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

Definition

Approved Clinical Trial means a Phase I, II, III or IV clinical trial that is conducted for the

prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

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

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

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

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

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

Qualified Individual means a Member eligible for Coverage under this 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 Use Disorder/psychiatric Facility before your effective date of Coverage, Coverage for the inpatient or Facility care will begin on the effective date of coverage only if:

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

Advise the Facility of your change in Coverage and request them to notify BCN of your Facility admission. This will assist BCN in managing your care.

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 gynocomastia
- 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.)
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures.

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 Durable Medical Equipment section for additional exclusions.)

9.9 Mental Health/Substance Use Disorder

Coverage does not include the following services:

- Care provided by Non-Participating facilities except for emergency admissions to the point of stabilization
- Psychoanalysis and open-ended psychotherapy
- Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal care designed to help in activities of daily living (ADL) or to keep from continuing unhealthy activities.
- Transitional living centers such as three-quarter house or half-way house, therapeutic, boarding schools, domiciliary foster care and milieu therapies such as wilderness programs, other supportive housing, and group homes
- Maintenance treatments for caffeine and opiate addiction
- Treatment of Chronic illnesses is limited to:
  - Treatment that is Medically Necessary to prevent an acute episode of Chronic illness: or
  - Treatment that is Acute exacerbation of Chronic illness (any level of care, subject to other exclusions).
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment.
- Treatment programs that have predetermined or fixed lengths of care
- Court ordered examinations, tests, reports or treatments that do not meet requirements for Mental Health or Substance Use Disorder coverage
- Marital counseling services
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider

- Gambling addiction issues
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining)
- Treatment of or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes

9.10 Court Related Services

There is no Coverage for:

- Court ordered services including but not limited to pretrial and court testimony, a court-ordered exam, or the preparation of court-related reports that does not meet Coverage requirements.
- Court-ordered treatment for Substance Use Disorder or mental illness except as specified in Section 8.
- Services related to your commission of a crime or participation in an illegal activity; and
- 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
- 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 lay-midwife and home births
- Infertility treatment including prescription drugs except for the diagnosis of infertility and in-vitro fertilization 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, and "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)
- Visual training or visual therapy for learning disabilities such as dyslexia
- Glasses, frames and contact lenses except as specified in Section 8
- Dilation

9.16 Unauthorized and Out-of-Plan Services

Except for emergency and urgent care as specified in Section 8 of this booklet, health, medical and hospital services listed in this Benefit Document are covered **only** if they are:

- Provided by a U-M Premier Care Network 1 or Network 2 affiliated provider; or
- Preauthorized by BCN

Any other services will not be paid for by BCN either to the provider or the Member. Additional information regarding Out of Area Services can be found at bcbsm.com or by calling Customer Service at the number provided on the back of your BCNSC ID Card.

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

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە ئێستا یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕێک، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە لەسەر پشتەوەی کارتەکەت، یان 877-469-2583 TTY: 711 ئەگەر ئێستا ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583,
TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.