

**Blue Care Network**  
**GRADCARE**  
**Certificate of Coverage**

# UNIVERSITY OF MICHIGAN GRADCARE CERTIFICATE OF COVERAGE

## Blue Care Network

This Certificate of Coverage describes the benefits provided under your Coverage. It is made up of two chapters: **General Provisions** and **Your Benefits** and may be amended at any time, upon mutual agreement between the University of Michigan, the University of Michigan Medical Benefits Plan (“Group Health Plan”) and Blue Care Network (“BCN”).

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

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

This Certificate of Coverage describes the benefits provided under your Coverage in accordance with the Administrative Services Contract (“ASC”).

By choosing to enroll as a BCN Member, you, the Member, agree to abide by the rules as stated in the General Provisions and Your Benefits. You also recognize that, except for emergency health services, only those health care services provided by your Primary Care Physician or arranged or approved by 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 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 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 GradCare Certificate of Coverage 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 BCN, however, neither BCN nor its subcontractors are responsible for insuring coverage for your benefits under GradCare.

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

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20500 Civic Center Drive  
Southfield, MI 48076  
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## **Definitions**

These definitions will help you understand the terms used in this Certificate of Coverage 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 BCN or another entity or person BCN authorizes to act on its behalf. The terms “you” or “your” refer to the Member, which may be enrolled as either a Subscriber or Family Dependent.

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

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

**Approved Amount also known as the Allowed Amount** is the lower of the billed charge or the maximum payment level BCN 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.

**Benefit** is a covered health care service available to you as described in this Certificate of Coverage.

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

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

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

**Chronic** is a disease or ailment that lasts a long time or recurs frequently. Arthritis, 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 or reprocessed. Your Coinsurance is not altered by an audit or recovery. 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 Or Facility that ends its participation with BCN. (See Section 8)

**Coordination of Benefits (COB)** means a process of determining which Certificate of Coverage or policy is responsible for paying benefits for Covered Services first (primary plan). When you have dual coverage, this allows the secondary plan to reduce its benefits, so that the combined

benefits of all plans do not exceed the total allowable fees. Benefit payments are coordinated between the two carriers to provide 100% coverage whenever possible for services covered in whole or in part under either plan, but not to pay in excess of the 100% of the total allowable amount to which you, as the Member, or the provider is entitled.

**Copayment or Copay** is a fixed dollar amount you must pay for a certain Covered Services usually when you receive the service. Your Copay is revised when a Rider 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 or Coinsurance) is the portion of the health care costs you may owe as defined in this Certificate of Coverage and any attached Riders. BCN pays the balance of the Allowed Amount for Covered Services.

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

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

**Deductible** is the amount that you must pay before BCN will pay for Covered Services. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed or reprocessed. Your Deductible is not altered by an audit 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 Subscriber providing completed enrollment information to the Group Health Plan and the Group Health Plan transmitting that information to 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 or rehabilitation due to illness or injury.

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

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

**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, psychiatric disorders or pulmonary tuberculosis.

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

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

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

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

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

**Medical Episode** is an acute incidence of illness or symptoms which is distinct from the Member'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;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease or it's symptoms;
- Not primarily for the convenience of the Member or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease;
- Not regarded as experimental by BCN;
- Rendered in accordance with BCN Utilization Management Criteria

**Member** (or you) means the eligible individual 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.

**Non-Participating or Non-Participating Provider** is an individual Provider, Facility, or other health care entity not under contract with BCN. Unless the specific Service is Preauthorized as

required under this Certificate, the Service will not be payable by BCN. You may be billed directly 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 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.

**Online Visit** is a structured real-time online health consultation using secure audio-visual technology to connect a BCN Participating Provider in one location to a Member in another location. The Member initiates the medical or behavioral health evaluation. The Online Visit is for the purpose of diagnosing and providing medical or behavioral health treatment for low-complexity non-emergent conditions within the provider's scope of practice.

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

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

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

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

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

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

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

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

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)

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

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

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

**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 your family member, friend or care giver can rest or take some time off from caring for you.

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

**Routine** means non-urgent, non-emergent, non-symptomatic medical care provided for 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 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.

**Subscriber** is the eligible individual who has enrolled for health care Coverage with BCN. This person's employment is the basis for Coverage eligibility. This person is also referred to as the "Member".

**Surprise Billing** is an instance where a Member unknowingly receives care from a Non-Participating Provider or receives care from a Non-Participating Provider because a Participating Provider is unavailable and later receives an unexpected bill for the difference between what the provider charges and what we pay. See Surprise Billing section under Chapter 1.

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

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

**Your Benefits** is Chapter 2 that provides a detailed description of Coverage, including exclusions and limitations.

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## CHAPTER 1 - GENERAL PROVISIONS

### Section 1: Eligibility, Enrollment & Effective Date of Coverage

All Subscribers must meet eligibility requirements set by BCN 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. BCN 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 of Guidelines

The following guidelines apply to all GradCare Members:

- **Medicare:** If you are not an active employee and become eligible to enroll in Medicare, you are eligible to enroll in only the amended U-M Premier Care Plan that coordinates coverage with Medicare. If you are not an active employee, you or your Family Dependent must enroll in and maintain both Medicare Part A and Medicare Part B when you are eligible. Except as otherwise provided by applicable law, Benefits for Members eligible for Medicare coverage are not duplicated. If Medicare is the primary payor or would be the primary payor if you or your Family Dependent enrolled in Medicare, your Benefits will be reduced accordingly.
- **Out of Service Area:** A Family Dependent choosing to register for out of service area coverage must reside outside of the following counties for at least three consecutive months: Genesee, Ingham, Jackson, Lapeer, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw or Wayne. In addition, for coverage, Family Dependents are required to receive services within 50 miles of the out of service area address registered with BCN. For additional information on registration procedures, please call BCN Customer Service at number listed in the Member Handbook or on the ID Card.

This does not change any other conditions of Coverage described in the Certificate of Coverage. 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 Certificate of Coverage; 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 ID Card.

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

The following Family Dependents are not covered:

- Family Dependents who are outside of the service area for vacation
- Family Dependents who reside outside the service area to attend school for less than one semester, or less than three (3) months
- Family Dependents who are not students and reside outside the Premier Care Provider Network I area for less than three (3) months
- Individuals who misrepresent that they are residing out of the Service Area are not covered
- Family Dependents who are not residents of the United States (or the portion of Canada within 50 miles of the Service Area)
- **Change of Status:** You agree to notify Group Health Plan within 30 days of any change in eligibility status of you or any Family Dependents. When you are no longer eligible for Coverage, you are responsible for payment for any services or benefits unless the services are covered under other health benefit plan or insurance.
- **If you were admitted to a hospital or skilled nursing facility** prior to the effective date of this Certificate of Coverage you will be covered for inpatient care on the effective date of Coverage only if:
  - You have no continuing coverage under any other health benefits contract, program or insurance;
  - BCN 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.
- **We will only pay for Covered Services you receive while** you are a Member and covered under this Certificate and attached Riders. Once your Coverage under this Certificate ends, any attached Riders to this Certificate will automatically end without further action or notice by BCN.

## Section 2: Other Party Liability

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

- Are not provided or Preauthorized by BCN and a Primary Care Physician; or
- Are not Covered Services under this Certificate of Coverage.

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

### 2.1 Nonduplication

- BCN Coverage provides you with benefits for health care services as described in this Certificate of Coverage.
- BCN does not duplicate benefits or pay more for Covered Services than the actual fees. This includes no duplicate benefits paid for no-fault auto related claims.

- Coverage described in this Certificate of Coverage will be reduced to the extent that the services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for the payment under such health plan or policy.

## **2.2 Workers' Compensation Claims and No-Fault Auto**

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

Benefits under this Certificate of Coverage will not be reduced for automobile claims 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 Certificate of Coverage in accordance with this Certificate of Coverage's terms and conditions.

If a Member is injured while riding a motorcycle due to an accident with an automobile, then the automobile insurance for the involved automobile is primary for the Member's medical services. BCN would provide for Covered Services under this Certificate as the secondary plan.

If a Member is injured in a motorcycle accident that does not involve an automobile and if the motorcycle insurance plan provides medical coverage, then BCN plan would pay as primary is primary. The motorcycle insurance plan would pay as the secondary plan.

## **2.3 Coordination of Benefits (COB)**

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

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

After those benefits are determined, 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 BCN of your right, or the rights of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

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

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

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

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

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

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

- ◆ Judgment or settlement of a legal action
- ◆ Settlement not due to legal action
- ◆ Undisputed payment

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

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

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

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

### ***Your Responsibilities***

In certain cases, BCN may have paid for health care services for you 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 BCN paid for your medical expenses for the purpose of subrogation. You grant BCN a Lien or Right of Recovery.  
Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held, 2) whether the money or other valuable consideration is designated as economic or non-economic damages, and 3) whether the recovery is partial or complete.
- You agree to inform BCN when your medical expenses should have been paid by another party but was not due to some act or omission.
- You agree to inform BCN when you hire an attorney to represent you, and to inform your

attorney of BCN's right and your obligations under this Certificate of Coverage.

- You must do whatever is reasonably necessary to help BCN recover the money paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining a written consent from BCN if payment was made for the treatment you received for that injury.
- You agree to cooperate with BCN in the efforts to recover money paid on your behalf.
- You acknowledge and agree that this Certificate of Coverage supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine or other Equitable Distribution Principles.

## **Section 3: Member Rights and Responsibilities**

### ***3.1 Confidentiality of Health Care Records***

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

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

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

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

### ***3.2 Inspection of Medical Records***

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

### ***3.3 Primary Care Physician***

You are required to select a Primary Care Physician (PCP). You have the right to designate any Primary Care Physician who is a Participating Physician and who is able to accept you or your family members.

For children under the age of 18 ("Minors"), you may designate a Participating pediatrician as the PCP 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 PCP, 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 Preauthorization from BCN or from any other person, including your PCP, in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetric and gynecologic care. The Participating specialist, however, may be

required to comply with certain BCN procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals. The female Member retains the right to receive the obstetrical or gynecological services directly from her PCP.

For information on how to select a PCP, and for a current list of Participating PCPs, Participating pediatricians and Participating health care professionals who specialize in obstetrics and gynecology contact Customer Service at the number provided on the back of your ID Card. You can also find this information at <https://www.bcbsm.com/>.

If after reasonable efforts, you and the PCP are unable to establish and maintain a satisfactory physician-patient relationship, you may be transferred to another PCP. 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 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. You receive a copy of this procedure when you become a Member. You also may obtain a copy at any time by contacting BCN at the number provided on your ID card.

### **3.5 Additional Member Responsibilities**

You have the responsibility to do the following.

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

## **Section 4: Forms, Identification Cards, Records and Claims**

### **4.1 Forms and Enrollment**

You must complete and submit any enrollment form or other forms that Group Health Plan, or BCN requests. You warrant that any information you submit is true, correct and complete.

The submission of false or misleading information in connection with Coverage is cause for

Rescission of your 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 on our website at <https://www.bcbsm.com/importantinfo>. To obtain a copy, you can call Customer Service at the number on the back of your ID card.

## **4.2 Identification Card**

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

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

If 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](https://www.bcbsm.com).

## **4.3 Misuse of Identification Card**

BCN may confiscate your ID card and may terminate Coverage if you misuse your ID card by doing any of the following.

- Permit any other person to use your card.
- Attempt to or defraud BCN.

## **4.4 Enrollment Records**

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

## **4.5 Authorization to Receive Information**

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

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

## **4.6 Member Reimbursement**

Your Coverage is designed to avoid the requirement that you pay a provider for Covered Services other than Copayment or Deductible when applicable. If, however, circumstances require you to pay a provider, BCN will reimburse you for those Covered Services if you provide written proof of

the payment within 12 months of the date of service.

Additional information regarding the process for submitting a claim for reimbursement and the Reimbursement Form are included in the Member Handbook.

**NOTE:** Claims submitted more than 12 months after the date of service will not be reimbursed by BCN.

## Section 5: Termination of Coverage

### 5.1 Termination of Coverage

Coverage described in this Certificate of Coverage 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 BCN to terminate the ASC. Benefits for all members of the group will terminate on the date the Certificate of Coverage terminates as permitted by law.

### 5.2 Termination for Nonpayment

#### *Nonpayment by Group*

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

#### *Nonpayment of Member Copayment and Deductible*

BCN may terminate Coverage under the following conditions:

- If you fail to pay Copayments or other fees within 90 days of their due date; or
- If you do not make or comply with acceptable payment arrangements with the Participating Provider to correct the situation.

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

### 5.3 Termination of a Member's Coverage

#### Termination

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

- a) You no longer meet eligibility requirements.
- b) Coverage is cancelled for nonpayment.
- c) You misuse your Coverage
  - a. Misuse includes illegal or improper use of your Coverage such as:
    - i. Allowing an ineligible person to use your Coverage
    - ii. Requesting payment for services you did not receive
- d) You fail to repay the Group Health Plan for payments we made for services that were not a benefit under this Certificate, subject to your rights under the appeal process

- e) You are satisfying a civil judgment in a case involving BCN
  - f) You are repaying the Group Health Plan funds you received illegally
  - g) You are serving a criminal sentence for defrauding BCN
  - h) Your group changes to a non-BCN health plan
  - i) The Group Health Plan no longer offers this coverage
- j) **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. Once we notify you that we are rescinding your Coverage, we may hold or reject claims during this 30-day period. In some circumstances, fraud or intentional misrepresentation of a material fact may include:
- Misuse of the BCN ID card (Section 4.3);
  - Intentional misuse of the BCN system; or
  - Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCN complaint and grievance procedure. You can find this procedure in your Certificate of Coverage, on our website at <https://www.bcbsm.com/> or you can contact Customer Service who will provide you with a copy.

## 5.4 Extension of Benefits

Your rights to BCN 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 Certificate of Coverage. 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.

## 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 BCN Coverage eligibility requirements as described in this Certificate of Coverage 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. To obtain information contact BCN Customer Service at the number on the back of your ID card or at: <https://www.bcbsm.com/>.

## 6.2 COBRA Coverage

If you no longer meet the eligibility requirements as described under Section 1 of this Certificate of Coverage, you may be able to continue Coverage at your own expense under federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act). Most employers with 20 or more employees are required by federal law to offer this coverage (continuation coverage). The employer is the administrator of its COBRA plan. If you have questions, you should contact the University of Michigan Benefits Office.

**NOTE:** Employers under 20 employees, church-related groups and federal employee groups are exempt from COBRA.

As the University of Michigan is required by COBRA to offer qualified beneficiaries as defined under the federal COBRA law the option of purchasing continuation coverage, you will need to be aware of the following conditions:

1. You may apply and pay for group continuation coverage directly to the University of Michigan, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
2. This coverage may continue for up to 18, 29 or 36 months, depending on the reason for your initial ineligibility.
  - You are considered a Group Member for all purposes, including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
  - Continuation coverage and all benefits cease automatically for a Group Member under any of the following:
    - The period allowed by law expires.
    - The University of Michigan no longer includes BCN Coverage as a part of its Group Health.
    - Member begins coverage under any other benefit program or health coverage plan (with some exceptions).
    - After electing COBRA continuation, Member becomes eligible for Medicare.
    - Member fails to pay for Coverage fully and on time.

## Section 7: General Provisions

### 7.1 Notice

Any notice that BCN is required to give to you will be

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

### 7.2 Change of Address

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

### **7.3 Headings**

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

### **7.4 Execution of Contract of Coverage**

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

### **7.5 Assignment**

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

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

### **7.6 BCN**

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

### **7.7 Litigation**

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

### **7.8 Reliance on Verbal Communications and Waiver by Agents**

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

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

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

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

### **7.9 Riders**

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 BCN.

### **7.10 Major Disasters**

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

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

Such circumstances include:

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

### **7.11 Obtaining Additional Information**

The following information is available:

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

You can obtain the information through these sources:

- Online at <https://www.bcbsm.com/>;

- By writing BCN Customer Service at P.O. Box 68767, Grand Rapids, MI 49516-8767;
- By calling our Customer Service Department at the number shown on the back of your BCN ID card; or
- By checking your BCN Welcome book

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

## **7.12 Right to Interpret Contract**

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

## **7.13 Out of Area Services**

Services under this Certificate of Coverage are covered only in the state of Michigan except for emergency or BCN authorized services. Services received outside of Michigan are administered through BlueCard®, a Blue Cross® and Blue Shield® Association Program. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

### Overview

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

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

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

## Inter-Plan Arrangements Eligibility – Claim Types

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

### A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when you access Out-of-Area Covered Healthcare Services outside the BCN Service Area, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

### Liability Calculation Method Per Claim

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

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

- (i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of billed charges for Out-of-Area Covered Healthcare Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount the Host Blue

pays to the provider. However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

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

### **1. Member Liability Calculation**

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

### **2. Exceptions**

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

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

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

### **General Information**

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Healthcare Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of

Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- **Inpatient Services**

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

- **Outpatient Services**

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

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

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. The claim form is available from BCN, the service center or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com). If you need assistance with the claim submissions, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

#### D. Exclusions and Limitations

This addendum will not apply if:

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

#### E. General Information

- If you are receiving services from a Host Blue Provider, you are responsible for the applicable Level 1 Cost Sharing.
- If you are receiving services from a non-participating host provider and the service is authorized by BCN, you are responsible for the applicable Level 2 Cost Sharing Until further notice, all the terms, definitions, limitations, exclusions and conditions of your Certificate and related Riders remain unchanged.

### **7.14 Unlicensed and Unauthorized Providers**

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

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

### **7.15 Special Programs**

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

We may terminate any special program based on:

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

### **7.16 SURPRISE BILLING**

Federal and Michigan state law require us to pay Non-Participating Providers certain rates for Covered Services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, you will only pay the Cost Share applicable to that service. The following situations are covered by the Surprise Billing laws:

- Covered Emergency Services at a Participating or a Non-Participating Facility
- Covered Services provided by Non-Participating Providers at a Participating Facility when you were admitted to the Facility within 72 hours after receiving a related Covered Emergency Service
- Covered non-emergency services rendered by a Non-Participating Provider at a Participating Facility when you did not have the ability or opportunity to choose a Participating Provider

## **Chapter 2 - Your Benefits**

### **Section 8: Your Benefits**

#### **Important Information**

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

## YOUR BENEFITS

- Your health care benefits are provided as a part of the Group Health Plan. BCN has contracted with the University of Michigan and Group Health Plan to administer your Coverage.
- The Services listed in this chapter are covered when services are provided in accordance with Certificate requirements (including Referral from PCP or other Participating Provider) and, when required, are Preauthorized or approved by BCN except in an Emergency.
- Medical Services defined in this Certificate are Covered Services only when they are Medically Necessary.
- Coverage is subject to the limitations and exclusions listed in this chapter.
- If you receive a service that we do not cover, you will be required to pay for that service.
- You are responsible for Copayment for many of the benefits listed.
- You are responsible for any amounts billed by Non-Participating Providers that exceed the Approved Amount when using Level 3 Services.
- 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:
  - Review of the diagnosis reported,
  - Verification of Medical Necessity
  - Availability of Benefits at the time the claim is processed
  - Conditions, limitations, exclusions, maximums
  - Coinsurance, Copayments and Deductible under your Certificate of Coverage and Riders.
- If you receive a service that is not covered, you will pay for that service.
- Your PCP or other Participating Provider must coordinate Referrals and Preauthorizations. You cannot self-refer unless specified in this Certificate.
- For a list of Services that require Preauthorization, contact Customer Service at the number provided on the back of your BCN ID card.
- BCN will manage or may direct your care to a surgical or treatment setting for Select Services.
- You can find information about other Benefits as listed below, in the Member Handbook or at [bcbsm.com](http://bcbsm.com)
  - Disease management
  - Prevention
  - Wellness
  - Care management services

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

If you have a Coinsurance or Copayment for a particular Service as well as a Deductible, you will first be responsible for the payment of the Deductible. The Coinsurance or Copayment will be based on the remaining balance of the Approved Amount. BCN 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 Certificate of Coverage per Calendar Year. The Out-of-Pocket Maximum includes your Level 1, Level 2 and Level 3 medical Cost Sharing. Once you reach the Out-of-Pocket Maximum, you do not pay for these services for the remainder of the Calendar Year with the following exceptions:

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

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

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

### **Out-of-Pocket Maximum**

- \$3,000 per Member
- \$6,000 per Family

NOTE: Your prescription drug coverage is administered through a separate pharmacy benefit manager not affiliated with BCN. As a result, the Out-of-Pocket Maximum amount defined in 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.

### **Level 1**

When you receive services from your PCP and only use other providers as arranged by your PCP,

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

### **Level 2**

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

### **Level 3**

When you are outside the GradCare Service Area on vacation or academic break, and you use a Provider without a referral from your Primary Care Physician, you will be responsible for the set dollar Copayment amount listed in this Certificate of Coverage plus any amount over the Approved Amount. Payments for any service that is not covered by GradCare are entirely your responsibility. Payments for any unauthorized services requiring prior authorization are also your responsibility.

### **Annual Copayment Maximum**

You have an Annual Copayment Maximum. This maximum applies to all three levels combined for Outpatient Mental Health and Outpatient Substance Use office visits. The Copayment Maximum is the most you will pay toward Outpatient Mental Health and Substance Use office visits. Once you reach the maximum, you will not pay Copayments for the remainder of the year.

- \$500 per Member
- \$1,000 per Family (when 2 or more Members are covered under the same contract)

## **8.2 Medical Professional Physician Services**

### **a) Office Visits including outpatient office site, hospital locations or Online Visits**

- Primary Care Physician (PCP)
- OB/GYN for female Members
- Referral physician
- Online Visit

We cover Online Visits by a BCN Participating PCP, Referral physician or online vendor selected by BCN to:

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

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

Online Visits apply the Cost Sharing for the type of Provider being seen.

NOTE: Not all virtual visit services are considered Online Visits, but maybe considered Telemedicine. Telemedicine services will be subject to the same Cost Sharing as services rendered in an office or other setting.

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

- Reporting of normal test results
  - Provision of educational materials
  - Handling of administration issues, such as registration, scheduling of appointments, or updating billing information
  - Visit with the BCN Online Vendor
- Eye Care – treatment of medical conditions and diseases of the eye – may require Preauthorization by BCN

Level 1 - \$25 Copayment for each office visit

Level 2 - \$25 Copayment for each office visit

Level 3 - \$25 Copayment for each office visit

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

**Referral Physician**

Level 1 - \$30 Copayment for each office visit

Level 2 - \$30 Copayment for each office visit

Level 3 - \$30 Copayment for each office visit

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

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

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered in full

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

c) **Home Visits** - provided by a physician in the home or temporary residence. For additional home health care services, please refer to Section 8.12

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered in full

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

d) **Inpatient Professional Services** - Physician services provided while the Member is in an Inpatient hospital or Skilled Nursing Facility are covered except for services listed in this Certificate of Coverage that have a specific Cost Sharing.

Level 1 - Covered in full

Level 2 - Covered in full for emergency admission only

- Not covered for non-emergent admissions

Level 3 - Covered for emergency admission only

- Not covered for non-emergent admissions
- Member is responsible for any amount billed by the Provider that exceeds the Approved Amount.

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

Level 1 - \$30 Copayment may apply to each office visit per Member. Injections covered in full

Level 2 - \$30 Copayment may apply to each office visit per Member. Injections are covered in full

Level 3 - \$30 Copayment may apply to each office visit per Member

- Injections are covered up to the Approved Amount
- You are responsible for any amount billed by the Provider that exceeds the Approved Amount

### **8.3 Continuity of Care for Professional and Facility Services**

#### **Continuity of Care for Existing Members**

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

#### Physician and Facility Requirements

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

- Notifies BCN of their agreement to accept the BCN Approved Amount as payment in full for the services provided
- Continues to meet BCN's quality standards;

- Agrees to adhere to the BCN medical and quality management policies and procedures.

#### Medical Conditions and Coverage Time Limits

- **Pregnancy Related:** If you are in your second or third trimester of pregnancy at the time of the treating physician's disaffiliation, services provided by your physician may continue through post-partum care (typically six weeks) for Covered Services directly related to your pregnancy.
- **Terminal Illness:** If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the disaffiliated provider related to your illness prior to the BCN contract end, Coverage for services provided by your provider may continue for the ongoing course of treatment through death.
- **Serious and Complex Medical Conditions:** For Chronic (on-going) life-threatening 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 provider'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 and Facility Requirements" listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment, subject to Medical Conditions and Coverage Time Limits detailed above. In order for additional Covered Services to be paid, your Participating Primary Care Physician must provide or coordinate all such services.

#### **Continuity of Care for New Members**

If you are a new Member and want to continue an active course of treatment from your existing, Non-Participating Provider, you may request enrollment in BCN's Continuity of Care program. At the time of enrollment, you must select a BCN Primary Care Physician who will coordinate your care with the Non-Participating Provider. You may participate in the Continuity of Care program only for the following conditions and only for the time periods described below:

#### Coverage Time Limits and Qualification Criteria

- **Pregnancy Related:** If you are in your second or third trimester of pregnancy at the time of enrollment, coverage provided by your Non-Participating Provider will continue through post-partum care for Covered Services directly related to your pregnancy.
- **Terminal Illness:** If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the Non-Participating Provider related to your illness prior to enrollment, coverage provided by your Non-Participating Provider will

continue for the ongoing course of treatment through death.

- **Serious and Complex 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 (Facility) Services**

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

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

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.

NOTE: Maternity Care includes coverage of the mother's newborn only during the 48 or 96 hours when the newborn has not been added to a BCN contract. These Services include:

- Newborn examination given by a physician other than the anesthesiologist or the mother's attending physician

## YOUR BENEFITS

- Routine Care during the newborn’s eligible hospital stay
  - Services to treat a newborn’s injury, sickness, congenital defects or birth abnormalities during the newborn’s eligible hospital stay
- Newborn care

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

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

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

Newborn Care includes:

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

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

### Coverage

Level 1 - Covered in full

Level 2 - Covered in full for emergency admission

- Not covered for non-emergent admissions except maternity care and delivery of newborn

Level 3 - Covered in full for emergency admission

- Not covered for non-emergent admissions except maternity care and delivery of newborn

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

See section 8.2 for Inpatient Professional Services Cost Sharing.

### 8.5 Outpatient Services

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

You receive Outpatient Services in the following places:

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

Outpatient Services include but are not limited to the following:

- Facility and professional (physician) Services
- 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 Medical Professional Physician Services section
- Professional Services - see Medical Professional Physician Services section
- Durable Medical Equipment and supplies - see Durable Medical Equipment section
- Diabetic equipment and supplies - see Durable Medical Equipment section
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics section
- Other Outpatient Services and supplies necessary for the treatment of the Member

## Coverage

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered

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

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

## 8.6 Emergency and Urgent Care

### Definitions

**Accidental Injury** - a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health

**Emergency Services** - services to treat emergency conditions as described above.

**Medical Emergency** - the sudden onset of a medical condition resulting from injury, sickness or behavioral health condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant 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 PCP 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 will apply.

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

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

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

- \$100 Copayment for Emergency Services provided in a hospital emergency room; waived if Member is admitted to hospital as a bed patient
- \$25 Copayment for Emergency Services in an Urgent Care Center

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

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

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

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

You are covered when traveling within or outside of the BCN Service Area for Emergency and Urgent Care Services that meet the conditions described above.

When Services are rendered by a Non-Participating Provider, we pay the greater of:

- The median in-network rate
- Rate we would pay a Participating Provider
- The Medicare rate.

You are responsible for any Cost Sharing required under your Certificate.

## **8.7 Ambulance**

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

For ground ambulance, a covered destination may include:

- A hospital
- A Skilled Nursing Facility
- A Member's home
- A dialysis center

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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

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

- The service must be Medically Necessary. Any other means of transport would endanger the Member's health or life
- Coverage only includes the transportation of the Member and whatever care is required during transport. Other services that might be billed with the transportation is not covered
- The service must be provided in a licensed ground or air ambulance that is part of a licensed ambulance operation

**Coverage also includes when:**

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

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

## Air ambulance

Air Ambulance services must also meet these requirements:

- No other means of transport are available
- The Member's condition requires transportation by air ambulance rather than ground ambulance
- An air ambulance provider is licensed as an air ambulance service and is not a commercial airline.
- The Member is transported to the nearest facility capable of treating the Member's condition.

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

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

- Transportation services or medical Services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated Services provided as part of a response to an accident or Emergency situation, like accident clean-up or 911 costs are not a covered benefit. This is because these Services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the Member's condition does not require air ambulance transport.
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.

## ***8.8 Preventive and Early Detection Services***

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

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

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

## YOUR BENEFITS

- 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
  - Female sterilization services
- **Newborn and well-child assessments and examinations**
- **Immunizations** (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN. Flu shots are covered in full.
- **Routine cancer screenings** including but not limited to colonoscopy, flexible sigmoidoscopy, and prostate (PSA/DRE) screenings (For the purposes of this document "Routine" means non-urgent, non-emergent, non-symptomatic medical care provided for the purpose of disease prevention.)
- **Depression screening** when performed by the Primary Care Physician

- **Nutritional counseling** including Diabetes Self-Management  
NOTE: Certain health education and health counseling services may be arranged through your Primary Care Provider, but are not payable under your Certificate of Coverage. Examples include but are not limited to birthing classes, lactation classes not provided by your physician, weight loss programs, tobacco cessation programs (other than a BCN tobacco cessation program), 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 or Coinsurance Riders, the attached Riders will take precedence over this Certificate of Coverage 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.

NOTE: To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to the following website: <https://www.healthcare.gov/coverage/preventive-care-benefits/> You may also contact BCN Customer Service .

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

### **Coverage**

Level 1 - Covered in full

Level 2 and Level 3 - Covered in full from an In-network Provider. Covered up to \$40.00 per Member per calendar year from a Non-Participating Optometry Provider.

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

Dilation, frames, lenses and contact lenses and contact lens fitting

## **8.9 Reproductive Care and Family Planning Services**

This benefit includes:

- Infertility

- Voluntary sterilization
- Termination of pregnancy
- Genetic testing

### **a) Infertility**

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.

Level 1 - \$30 Copayment may apply to each office visit per Member

Level 2 - \$30 Copayment may apply to each office visit per Member

Level 3 - \$30 Copayment may apply to each office visit per Member

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

**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;
- 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.

Note: Time frames may be altered based on clinical indication of diminished ovarian reserve identified by provider.

- 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.

Note: Time frames may be altered based on clinical indication of diminished ovarian reserve identified by provider.

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

### **Limitations**

YOUR BENEFITS

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.

\*Number of transferred embryos allowed may be altered if specific clinical criteria are met based on prior failed IVF attempts or embryo quality, as determined by the provider.

<b>In-Vitro Fertilization</b>	
<p><b>Level 1</b> Services must be rendered by the University of Michigan Health System; Center for Reproductive Medicine.</p>	<p>Covered 80%; 20% Coinsurance for all IVF procedures, professional services and related services; The 20% Coinsurance applies to the Out-of-Pocket Maximum.</p> <p>Covered IVF and fertility preservation services are subject to a combined Lifetime Maximum of \$20,000 per female Member. Once the Lifetime Maximum has been reached, IVF services are no longer covered under this Certificate of Coverage.</p> <p>NOTE: Diagnostic work-up, ultrasounds, counseling and labs already covered are excluded from the lifetime maximum.</p>
<p><b>Levels 2 and 3</b></p>	<p>Not a covered benefit</p>

***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 or male 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 BCN 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) Fertility Preservation**

Standard fertility preservation services are covered when a medically necessary surgical or medical treatment may directly or indirectly result in iatrogenic infertility to a covered person. In addition, standard infertility services will be covered for members up to age 26 in cases where a genetic condition will result in early menopause or impaired sperm production and cause infertility in subsequent years.

Definitions

**Iatrogenic Infertility** is an impairment of fertility by surgery, radiation, chemotherapy or medical treatment affecting the ability to produce sperm or eggs.

**Fertility Preservation** is the retrieval of mature eggs or sperm or the creation of embryos that are frozen for future use.

**Covered Procedures**

Females:

- oocyte retrieval, cryopreservation and storage for one year or;
- oocyte retrieval, fertilization, embryo cryopreservation and storage for one year.

Males:

- Semen cryopreservation and storage for one year
- Testicular aspiration to retrieve sperm when medically necessary

**Limitations**

- Iatrogenic infertility is covered for female Members up to the age of 43.
- Members with a genetic condition that will result in early menopause or impaired sperm production in later years are covered up to age 26

**Exclusions include but are not limited to**

- Long-term oocyte or embryo storage
- Long-term semen storage
- Fertility Preservation prior to voluntary sterilization procedures

Fertility Preservation	
<p><b>Level 1</b> Services must be rendered by the University of Michigan Health System; Center for Reproductive Medicine.</p>	<p>Covered 80%; 20% Coinsurance 20% Coinsurance applies to the Out of Pocket Maximum.</p> <p>Covered Fertility Preservation and IVF services are subject to a combined Lifetime Maximum of \$20,000 per Member. Once the Lifetime Maximum has been reached,</p>

	Fertility Preservation services are no longer covered under this Certificate of Coverage.
Levels 2 and 3	Not a covered benefit

### **c) Voluntary Sterilization**

Coverage includes Inpatient, Outpatient, and office based adult sterilization services.

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

#### Male sterilization

Level 1 - \$30 Copayment may apply to each office visit per Member

Level 2 - \$30 Copayment may apply to each office visit per Member

Level 3 - \$30 Copayment may apply to each office visit per Member

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

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

- Reversal of surgical sterilization for males and females

### **d) Termination of Pregnancy**

Coverage includes first trimester elective termination of pregnancy and therapeutic termination in the 2<sup>nd</sup> or 3<sup>rd</sup> trimester in accordance with locally accepted medical practice.

Level 1 - \$30 Copayment for each office visit

Level 2 - \$30 Copayment for each office visit

Level 3 - Not covered

### **e) Genetic Testing**

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

Level 1 - \$30 Copayment may apply per Member for each visit

Level 2 - \$30 Copayment may apply per Member for each visit

Level 3 - \$30 Copayment may apply per Member for each visit

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

NOTE: Genetic counseling and BRCA testing 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 up to a total cumulative maximum of 45 days per Calendar Year when Medically Necessary for recovery from surgery, disease or injury. This Benefit includes hospice care in a Skilled Nursing Facility. The care must be Preauthorized by your Primary Care Physician and BCN.

**Coverage**

Level 1 – Covered in full

Level 2 – Covered in full

Level 3 – Covered

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

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

**Exclusions include but are not limited to**

- Bed-hold charges incurred when you are on an overnight or weekend pass during an Inpatient stay
- 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;
- Other health care services approved by BCN when they are performed in the Member's home.

**Coverage**

Level 1 - \$30 Copayment each day a visit occurs

Level 2 - \$30 Copayment each day a visit occurs

Level 3 - \$30 Copayment each day a visit occurs

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

**Exclusions include but are not limited to**

- Housekeeping services
- 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 six months or less. Hospice Care is designed to provide comfort and support to Members and their families when a life-limiting illness no longer responds to cure-oriented treatments.

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

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

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

**Coverage**

Level 1 - Covered in full

Level 2 - Not covered

Level 3 - Not covered

**Exclusions include but are not limited to**

- 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 skilled nursing home). Home infusion therapy services are covered when Medically Necessary and Preauthorized by BCN.

Food Supplements*Supplemental feedings administered via tube:*

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

*Supplemental feedings administered via an IV:*

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

**Coverage**

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered

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

**8.14 Behavioral Health Services****A. Mental Health Care**

We cover evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions. Non-Emergency Mental Health services must be Preauthorized as Medically Necessary by BCN with the **exception** of routine outpatient psychiatry and psychotherapy services. (Mental Health Emergency Services are covered pursuant to Emergency and Urgent Care Section 8.6)

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

**Definitions:**

- **Inpatient Mental Health Service** is the service provided during the time you are admitted to a BCN approved acute care Facility that provides continuous 24-hour nursing care for comprehensive treatment.
- **Residential Mental Health Treatment** is treatment that takes place in a licensed domiciliary facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 or available afterhours with a response time of 60 minutes to the facility to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential treatment is:
  - Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
  - A structured environment that will allow the individual to reintegrate into the community - It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long-term means of protecting others in the Member's usual living environment; and

- Not based on a preset number of days such as standardized program (i.e. “30-Day Treatment Program”), however, the benefit design will be the same as your medical inpatient benefit when Preauthorized by BCN.
- **Partial Hospitalization Mental Health** is a comprehensive, acute care program that consists of a minimum of 4 hours per day, 3 days a week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of inpatient psychiatric hospitalization.
- **Intensive Outpatient Mental Health** services are acute care services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 3 days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan.
- **Outpatient Mental Health** services include individual, conjoint, family or group psychotherapy, psychiatric evaluation, counseling, medical testing and crisis intervention.

### Coverage

Mental health care is covered in either an Inpatient or Outpatient settings. To obtain services call Behavioral Health Management at the number provided on the back of your BCN ID card. They are available 24 hours a day, 7 days a week. You do not need a Referral from your Primary Care Physician to get care.

a) **Outpatient Mental Health/Intensive Outpatient Mental Health**; no matter the location including Online Visits

Level 1 - \$25 Copayment per visit\*

Level 2 - \$25 Copayment per visit\*

Level 3 - \$25 Copayment per visit\*

\* A \$500 per member/ \$1,000 per contract annual copayment maximum applies to all three Levels combined for Outpatient Mental Health and Outpatient Substance Use office visits, no matter the location.

b) **Inpatient Mental Health/Residential Treatment/Partial Hospitalization**

Level 1 - Covered in full

Level 2 - Covered in full for emergency admission only

- Not covered for non-emergent admissions

Level 3 - Covered for emergency admission only

- Not covered for non-emergent admissions

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.

### B. Substance Use Disorder Services

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

Non-Emergency Substance Use Disorder treatments must be Preauthorized as Medically Necessary by BCN with the exception of routine outpatient psychotherapy services. (Substance Use Disorder Emergency Services are covered pursuant to Emergency and Urgent Care Services Section 8.6)

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

### **Definitions**

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

**Residential Substance Use Disorder Treatment** means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical hospitalization. Residential services may include 24-hour professional supervision and may include counseling, Detoxification, medical testing, diagnostic and medication evaluation and referral or other services specified in a treatment plan. Residential Substance Use Disorder Treatment is sometimes referred to as Intermediate Care. Residential Substance Use Disorder is not considered inpatient-acute medical/surgical care in a hospital.

**Intermediate Care** refers to Substance Use Disorder Services that have a residential (overnight) component. Intermediate Care includes Detox, Domiciliary Partial and residential (including “inpatient”) Services.

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

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

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

**Intensive Outpatient Substance Use Treatment** means treatment that is provided on an Outpatient basis consisting of a minimum of 3 hours per day, 3 days per week and might include but are not limited to individual, group and family counseling, medical testing, diagnostic and medication evaluation and referral to other services specified in a treatment plan.

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

### **Coverage**

Substance Use 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. You do not need a Referral from your Primary Care Physician to get care.

The following services are covered:

a) **Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder**

Level 1 - \$25 Copayment per visit\*

Level 2 - \$25 Copayment per visit\*

Level 3 - \$25 Copayment per visit\*

\* A \$500 per member/ \$1,000 annual copayment maximum applies to all three Levels combined for Outpatient Mental Health and Outpatient Substance Use office visits, no matter the location.

b) **Detoxification/Residential/Intermediate Care/Partial Hospitalization/Partial Domiciliary Substance Use Disorder**

Level 1 – Covered in full

Level 2 – Covered in full for emergency admission only

- Not covered for non-emergent admissions

Level 3 – Covered for emergency admission only

- Not covered for non-emergent admissions

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 or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders. AAEC evaluation is necessary for ABA.

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

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

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

**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 Certificate of Coverage.

### **Benefits**

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

Note: A BCN approved AAEC must confirm the Member has Autism Spectrum Disorder (ASD) prior to receiving Applied Behavioral Analysis.

The following services for the treatment of ASD are covered:

- 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 Licensed Behavior Analyst and Participating psychologist;
  - Outpatient mental health therapy (when performed by a Participating social worker, Participating clinical psychologist and Participating psychiatrist);

## YOUR BENEFITS

- 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 Certificate of Coverage or related Riders.

### 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 the Level 1, Level 2 or Level 3 Office Visit Copayment as defined in this Certificate of Coverage. You are required to pay your Copay at the time the service is rendered.

Level 1 - \$25 Copayment per visit

Level 2 - \$25 Copayment per visit

Level 3 - \$25 Copayment per visit - Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Note: ABA services are not available outside of Michigan.

Behavioral health services included in the Treatment Plan are subject to the Level 1, Level 2 or Level 3 Office Visit Copayment as defined in this Certificate of Coverage. You are required to pay your Copayment at the time the service is rendered:

Level 1 - \$25 Copayment per visit

Level 2 - \$25 Copayment per visit

Level 3 - \$25 Copayment per visit – Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Note: The \$500 per member/ \$1,000 per contract annual copayment maximum that applies to all three Levels combined for Outpatient Behavioral Health also applies to Outpatient Behavioral Health with an autism diagnosis.

Outpatient rehabilitation services included in the Treatment Plan are subject to the Level 1, Level 2 or Level 3 Office Visit Copayment as defined in this Certificate of Coverage. You are required to pay your Copayment at the time the service is rendered.

## YOUR BENEFITS

Level 1 - \$25 Copayment per visit

Level 2 - \$25 Copayment per visit

Level 3 - \$25 Copayment per visit – Member is responsible for any amount billed by the Provider that exceeds the Approved Amount

Services performed pursuant to the recommended Treatment Plan will not count toward benefit maximums defined in this Certificate of Coverage 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 Certificate of Coverage such as

- exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities
- treatment solely to improve cognition concentration 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 - Level 1, Level 2 and Level 3 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, Level 1, Level 2 and Level 3 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 Approved Amount.
- Required Diagnosis for ABA – In order to receive Preauthorization, the Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, Participating developmental pediatrician or other professional as agreed upon by a BCN AAEC. 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 children up to and including the age of 18. This age limitation does not apply to outpatient mental health services (excluding applied behavioral analyses services) and services used to diagnose ASD. Benefits for ASD terminate on the child's 19th birthday.
- Treatment Plan - Level 1, Level 2 and Level 3 services must be included in a Treatment Plan recommended by a BCN 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 Outpatient Rehabilitation**

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

- Physical therapy
- Occupational therapy
- Speech therapy – includes coverage for gender affirming voice and communication therapy
- Medical rehabilitation – includes but not limited to cardiac and pulmonary Rehabilitation
- Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to BCN medical policies.

#### **Physical therapy, occupational therapy and speech therapy**

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

**Benefit Limitations:** Treatment for conditions considered to have a major diagnosis is limited to 60 visits per medical episode per calendar year for any combination of physical, occupational, and speech therapy. Treatment for conditions that are considered to have a minor diagnosis is limited to 15 visits per 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.

Level 1 - \$25 Copayment per session

Level 2 - \$25 Copayment per session

Level 3 - \$25 Copayment per session

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

**NOTE:** The benefit days under Level 1, Level 2 and Level 3 are cumulative. For example, use of a benefit day under Level 1 Coverage will reduce the benefit days available under Level 1, Level 2 and Level 3 Coverage. When two or more therapies are received on the same treatment day, each type of therapy counts as one visit. For example, if you have physical and occupational therapy on the day, it counts as two visits against your limit.

**General exclusions include but are not limited to**

- Cognitive retraining
- Vocational rehabilitation
- Therapy to maintain current functional level and prevent further deterioration
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency

**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

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

**Cardiac Rehabilitation**

Covered up to 36 sessions during an 18 week period per Medical Episode

Level 1 - \$25 Copayment per Member per session

Level 2 - \$25 Copayment per Member per session

Level 3 - \$25 Copayment per Member per session

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

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

**Pulmonary Rehabilitation**

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

Level 1 - \$25 Copayment per Member per session

Level 2 - \$25 Copayment per Member per session

Level 3 - \$25 Copayment per Member per session

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

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

## 8.17 Diabetic Supplies and Durable Medical Equipment

### Definitions

Diabetic supplies and equipment 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 for purchase or rental. It must be intended for repeated use and be useful primarily as a result of illness, injury or congenital defect.

### Coverage

We cover rental or purchase of DME when limited to the basic equipment. Any supplies required to operate the equipment and special features must be Medically Necessary and Preauthorized by BCN. Items must be obtained from a Participating DME Provider or a Participating facility upon discharge.

Basic diabetic supplies and equipment are covered when Medically Necessary, prescribed by the treating physician and obtained from a Participating Provider.

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

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

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered

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

### Limitations

- The equipment must be considered DME under your Coverage, and must be appropriate for home use.
- You must obtain the equipment from a BCN-approved supplier.
- Your Primary Care Physician or a Participating Provider must prescribe the equipment, and it must be Preauthorized by BCN.
- The equipment is the property of DME provider. When it is no longer Medically

Necessary, you may be required to return it to the supplier.

- Repair or replacement, fitting and adjusting of DME is covered only when needed as determined by BCN resulting from body growth, body change or normal use. Repair of the item will be covered if it does not exceed the cost of replacement.

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

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

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the Member and required so the Member can operate the equipment himself. (NOTE: If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the Member's option. You are responsible for any costs over the Approved Amount for the deluxe item that may be prescribed.)
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as 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 (See Section 9)  
Needles and syringes for purposes other than the treatment of diabetes  
Repair or replacement due to loss or damage or damage that can be repaired
- Assistive technology and adaptive equipment such as computers, supine boards, prone standers and gait trainers
- Modifications to your home, living area or motorized vehicles - This includes equipment and the cost of installation of equipment such as central or unit air conditioners, swimming pools and car seats
- 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

## **8.18 Prosthetics and Orthotics**

### **Definitions:**

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

- External: Prosthetic Devices - Devices such as an artificial leg, artificial arm or the initial

set of prescription lenses for replacement of an organic lens of the eye following Medically Necessary eye surgery (e.g. cataract surgery) are considered external devices. or

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

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

### Coverage

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

### Coverage includes but is not limited to:

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

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

Level 1 - Covered in full

Level 2 - Covered in full

Level 3 - Covered

The Member is responsible for any amount in excess of the Approved Amount.

### **Limitations**

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

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

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

- Sports-related braces
- Dental appliances, including bite splints
- Eyeglasses or contact lenses (except after lens surgery and for treatment of Keratoconus as listed above)
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, wigs and hairpieces
- Over the counter arch supports, foot orthotics or shoe inserts that are not attached to a leg brace
- Devices that are experimental and research in nature
- Items for the convenience of the Member or caregiver
- Duplicate appliances and devices
- Repair or replacement due to loss, theft, damage or damage that cannot be repaired

### **8.19 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 BCN Recipient**

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

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

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

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

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

Level 1 - Covered in full

Level 2 - Covered in full for emergency admission only

- Not covered for non-emergent admissions

Level 3 - Covered for emergency admission only

- Not covered for non-emergent admissions

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

Community wide searches for a donor

## ***8.20 Reconstructive Surgery***

### ***Definition***

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

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

### ***Coverage***

Reconstructive surgery is covered as defined above when it is Medically Necessary and Preauthorized by BCN.

Level 1 - Covered in full

Level 2 - Covered in full for emergency admission only

- Not covered for non-emergent admissions

Level 3 - Covered in full for emergency admission only

- Not covered for non-emergent admissions
- Member is responsible for any amount in excess of Approved Amount

## **8.21 Oral Surgery**

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

- 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.

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

## **Coverage**

Level 1 - \$30 Copayment for each office visit

Level 2 - \$30 Copayment for each office visit

Level 3 - \$30 Copayment for each office visit

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

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

## **8.22 Temporomandibular Joint Syndrome (TMJ) Treatment**

### **Definition**

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

### **Coverage**

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

Covered Services include:

## YOUR BENEFITS

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

Level 1 - \$30 Copayment for each office visit

Level 2 - \$30 Copayment for each office visit

Level 3 - \$30 Copayment for each office visit

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

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

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

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

## ***8.23 Orthognathic Surgery***

### ***Definition***

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

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

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

### ***Coverage***

Level 1 - \$30 Copayment for each office visit

Level 2 - \$30 Copayment for each office visit

Level 3 - \$30 Copayment for each office visit

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

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

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

***8.24 Weight Reduction Procedures***

Weight reduction procedures and surgery are covered when all of the following conditions are met:

- The BCN medical criteria and established guidelines related to the procedure
- The procedure is Preauthorized BCN as Medically Necessary
- Surgery is performed by the University of Michigan Health System

***Coverage***

Level 1 - \$1,000 Copayment or 50% whichever is less for all fees associated with weight reduction procedures, including related facility and professional services.

Level 2 - Not covered

Level 3 - Not covered

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

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

***8.25 Transgender Care***

Gender-affirming surgery, which has historically been referred to as gender reassignment surgery (GRS) or sex reassignment surgery (SRS), involves the changing to a different sex 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.

***Gender Affirming Surgery***

Covered Services are limited to:

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

***Coverage***

Level 1 - Covered in full

Level 2 - Not covered

Level 3 - Not covered

**Exclusions include but are not limited to**

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

NOTE: Gender affirming voice and communication speech therapy is covered. See Section 8.16 Outpatient Rehabilitation for speech therapy limits.

**Facial Hair Removal, Facial Feminization Procedures and Chondrolaryngoplasty**

a) **Facial Hair Removal (face and neck)** is covered when Medically Necessary and as determined by the criteria defined below and Preauthorized by BCN. Members must meet the following criteria for Coverage:

- The Member has persistent, well-documented gender dysphoria manifested by clinically significant distress and by significant functional impairment. This assessment has been made via a detailed psychological assessment and documented by a Participating mental health professional (either psychiatrist, PhD prepared clinical psychologist or master's level clinician who is licensed to practice independently in their state);
- 18 years of age or older;
- Capacity to make a fully informed decision and to consent for treatment;
- If significant medical or mental health concerns are present, they must be controlled

b) **Facial Feminization procedures and chondrolaryngoplasty (Adam's apple reduction)** are covered when Medically Necessary and as determined by the criteria defined below and Preauthorized by BCN. Covered procedures include:

- ✓ Forehead contouring/reconstruction
- ✓ Mandible contouring/reconstruction
- ✓ Rhinoplasty
- ✓ Genioplasty
- ✓ Blepharoplasty
- ✓ Lip lift via alar base excision
- ✓ Chondrolaryngoplasty

The following criteria must be met for Coverage to apply:

- The Member has persistent, well-documented gender dysphoria manifested by clinically significant distress and by significant functional impairment. This assessment has been made via a detailed psychological assessment and documented by a Participating mental health professional (either psychiatrist, PhD prepared clinical psychologist or master's level clinician who is licensed to practice independently in their state);

- 18 years of age or older;
- Capacity to make a fully informed decision and to consent for treatment;
- If significant medical or mental health concerns are present, they must be controlled;
- 12 continuous months of hormone therapy (estrogen), unless there is a medical contraindication to hormonal therapy;
- 12 continuous months of living as a woman

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

- ✓ Rhytidectomy
- ✓ Otoplasty
- ✓ Lip enhancement (filler, vermilion augmentation)
- ✓ Hair transplantation/hairline repositioning
- ✓ Dermabrasion
- ✓ Chemical peel
- ✓ Collagen injections

***Coverage***

Level 1 - Covered in full\*

Level 2 - Not covered

Level 3 - Not covered

\*Note: Covered facility and professional services for Facial Hair Removal, Facial Feminization Surgery and Chondrolaryngoplasty are subject to a Lifetime Maximum of \$30,000 per Member. Once the Lifetime Maximum has been reached, these services are no longer covered under this Certificate of Coverage.

***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 this section and in Section 8.

***8.26 Hearing Aid***

**DEFINITIONS**

**Audiologist** is a professional who is licensed or legally qualified in the State of Michigan to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems. They may dispense and fit hearing aids as part of a comprehensive rehabilitative program.

**Audiometric Hearing Aid Examination** is a procedure to evaluate hearing and measure hearing loss. The examination includes:

- Tests for measuring hearing acuity relating to air conduction
- Bone conduction
- Speech reception threshold and speech discrimination
- Summary of findings

**Binaural Hearing Aids** are two electronic devices (one set) delivered on the same day worn by the patient to amplify sound and improve hearing in both ears.

**Bone Anchored Hearing Aid** is a bone conduction Hearing Aid composed of a titanium screw that is surgically implanted in the temporal bone behind the ear.

**Conformity Evaluation Test** is a follow-up visit to the physician specialist, Audiologist or Hearing Aid Dealer who prescribed the Hearing Aid to verify receipt of the prescribed Hearing Aid and evaluate its comfort, function and effectiveness. Necessary adjustments are made to assure optimal amplification and performance.

**Ear Mold** is a device made of soft rubber, plastic, or non-allergenic materials, vented or non-vented, that is fitted to the outer ear canal and pinna of the patient.

**Hearing Aid** is an electronic device worn to amplify sound and improve hearing. A conventional Hearing Aid (Monaural or Binaural) is a standard adjustable Hearing Aid that fits inside the ear, behind the ear, or on the body. A Hearing Aid may also include an Ear Mold or a Bone Anchored Hearing Aid, if determined to be Medically Necessary in accordance with BCN medical policy.

**Hearing Aid Dealer** is a specialist who is licensed by the State of Michigan to perform:

- Audiometric Examinations,
- Hearing Aid Evaluation Tests,
- Conformity Evaluation Tests and
- to sell prescribed Hearing Aids.

**Hearing Aid Evaluation Test** determines what type of Hearing Aid should be prescribed to compensate for loss of hearing, based on the results of the Audiometric Exam.

**Monaural Hearing Aid** is a single electronic device worn to amplify sound and to improve hearing in one ear.

Covered services include:

- One (1) hearing evaluation test by a Participating Physician or Participating Audiologist to determine if a hearing problem exists
- An Audiometric Hearing Examination Test to determine hearing acuity and the specific type or brand of Hearing Aid needed
- Standard Monaural or Binaural Hearing Aids

YOUR BENEFITS

- 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
- A Bone Anchored Hearing Aid is also a Covered Benefit if, in accordance with BCN medical policy, the conventional Hearing Aid does not appropriately treat a Member's medical need, and, pursuant to BCN medical necessity criteria and policy, the Bone Anchored Hearing Aid is necessary therapeutic alternative to the conventional Hearing Aid. Bone Anchored Hearing Aid must be preauthorized by BCN.

**Limitations**

- The hearing care services must be authorized and performed by a Participating Provider or Participating Audiologist in the U-M Hearing Network Level 1 or Level 2. The Hearing Aid(s) must be dispensed by a Participating Provider (Hearing Aid Dealer or specialist) in the Value Based Hearing network, or the Standard Hearing network
- Hearing aids must be monaural, 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 are available only after 36 months have elapsed since the previous Audiometric Hearing Aid Examination, Hearing Aid Evaluation, Conformity Evaluation Test and the dispensing of a Monaural Hearing Aid or Binaural Hearing Aids.
- Ear Molds can be purchased separately from the Hearing Aid(s). Hearing Aid frequency limitation applies to adult Ear Molds.
- Custom Ear Molds for children under the age of 18 covered according to the following schedule:
  - Under three years of age: four times every 12 months per hearing aid
  - Age three up to 13 years of age: twice every 12 months per hearing aid
  - Age 13 up to 18 years of age: once every 12 months per hearing aid

**Coverage**

Level 1 - \$30 Copayment for each office visit  
 Level 2 - \$30 Copayment for each office visit  
 Level 3 - \$30 Copayment for each office visit

Hearing Services	
Level 1 <ul style="list-style-type: none"> <li>• Value Based Hearing Network: Includes Michigan Medicine Audiology and TruHearing providers</li> <li>• Standard Hearing network: Includes all other BCN contracted Audiology providers</li> </ul>	<ul style="list-style-type: none"> <li>• Value Based Hearing network providers will be paid the BCN Allowed Amount for coverage of a 'standard' model (either monaural or binaural) and will offer 'standard' options that do not result in Balance Billing. The Member can buy up to more advanced models as needed and be Balance Billed for the difference.</li> <li>• Standard Hearing network providers will be paid the BCN Allowed Amount for coverage of a 'standard' model (either monaural or binaural). Members may be Balance Billed for the</li> </ul>

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	difference between the BCN Allowed Amount and the provider charge for 'standard' models. The Member can buy up to more advanced models as needed and be Balance Billed for the difference.
<p>Levels 2 &amp; 3</p> <ul style="list-style-type: none"> <li>Out of State BlueCard and non-contracted Audiology providers</li> </ul>	<ul style="list-style-type: none"> <li>Providers will be reimbursed the Allowed Amount for coverage of a 'standard' model (either monaural or binaural). Members may be Balance Billed for the difference between the Allowed Amount and the provider charge for 'standard' models. The Member can buy up to more advanced models as needed and be Balance Billed for the difference.</li> </ul>

**Exclusions include but are not limited to**

- Replacement of Hearing Aids that are lost or broken unless you have not used this benefit for at least 36 months.
- Replacement parts including batteries, maintenance, repair and insurance expenses for Hearing Aids.
- Eye-glass type Hearing Aids, Cosmetic services or equipment.
- Hearing Aids ordered prior to the effective date of Coverage under this Certificate, even if delivered after Coverage begins.
- Hearing Aids ordered prior to the termination of Coverage under this Certificate, but delivered after the Coverage ends.
- Charges for Audiometric Examinations, Hearing Aid Evaluation Tests, Conformity Tests and Hearing Aids which are not necessary according to professionally accepted standards of practice or which are not prescribed by a Participating Provider.
- Drugs or medications related to hearing problems.
- Examinations, test or Hearing Aids provided by a government agency at no cost to the Member.
- Two hearing aids ordered on different dates. These are not considered Binaural Hearing Aids.
- Charges for spare Hearing Aids.
- Hearing Aids that do not meet the Food and Drug Administration and Federal Trade Commission requirements.
- Non-prescription, non-conventional Hearing Aids and devices.

**8.27 Prescription Drugs and Supplies**

Covered Prescription Drugs

**a) Prescription Drugs Received while you are an Inpatient**

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

**b) Cancer Drug Therapy**

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

Coverage is provided for the drug, regardless of whether the cancer is the specific cancer the drug

was approved by the FDA to treat, if all of the following conditions are met:

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

**Cancer Drug Therapy - Covered in full**

**Cost of administration - Covered in full**

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

#### c) Injectable Drugs

The following drugs are covered as medical benefits.

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

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

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

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

Drugs not approved by the FDA. Drugs not reviewed or approved by BCN. Experimental or investigational drugs as determined by BCN. 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 BCN Prescription Drug Rider.

#### d) Outpatient Prescription Drugs

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

### ***8.28 Clinical Trials***

## Definitions

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

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

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

**Phase I:** Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients.

**Phase II:** The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety.

**Phase III:** If a treatment has shown to be effective in Phase II, it is subjected to additional scrutiny in Phase III. In this phase, the sample size of the study population is increased to between 1,000 and 3,000 people. The goals in Phase III are to confirm the effectiveness noted in Phase II, monitor for side effects, compare the study treatment against current treatment protocols, and collect data that will facilitate safe use of the therapy or treatment under review.

**Phase IV:** These studies are done after the drug or treatment has been marketed or the new treatment has become a standard component of patient care. These studies continue testing the study drug or treatment to collect information about their effect in various populations and any side effects associated with long-term use. Phase IV studies are required by the FDA when there are any remaining unanswered questions about a drug, device or treatment.

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

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

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

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

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

are covered under this Certificate of Coverage or any attached Riders for Members who are not participants in an Approved Clinical Trial. They do not include:

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

### **Coverage**

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

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

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

### **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
- Coverage for Services not otherwise covered under this Certificate of Coverage
- Drugs or devices provided to you during a BCN approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the Member’s condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device

- Complications resulting from an Experimental procedure

## **Section 9: Exclusions and Limitations**

This section lists the exclusions and limitations of this Certificate of Coverage. Please refer to a specific service within this 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/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 Certificate of Coverage. 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 Certificate of Coverage
- Private duty nursing
- Services provided or performed by a Chiropractor
- Male mastectomy for treatment of gynecomastia
- Cognitive services including but not limited to those pertaining to perception, attention, memory or judgment, Examples include but are not limited to, cognitive training, retraining and rehabilitation; skills and memory therapies; stress reduction; relaxation therapies; and biofeedback
- Food and dietary supplements, vitamins, minerals, and infant formula (This exclusion does not apply to enteral feedings when they are your or a Dependent's sole source of nutrition.)
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Experimental or investigational procedures, treatments, drugs or devices
- 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;
- 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 such as treatment of or programs for sex offenders or perpetrators of sexual or physical violence;
- Marital counseling services;
- Religious oriented counseling provided by a religious counselor who is not a Participating Provider;
- Care, services, supplies or procedures that is cognitive in nature (such as memory enhancement, development or retraining);
- Services to hold or confine a person under chemical influence when no medical services are required;
- The costs of a private room or apartment; and
- Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes are not covered as separate charges.

#### **9.4 Cosmetic Surgery**

Cosmetic surgery is surgery done primarily to improve appearance 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 Certificate of Coverage.

## **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**

Custodial Care is used for maintaining your basic need for food, shelter, housekeeping services, clothing and help with activities of daily living. There is no coverage for Custodial Care.

This means that Custodial Care is not covered in your home, a nursing home, residential institution such as a three-quarter house or half-way house placement or 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 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.
- There is no coverage for court-ordered treatment for Substance Use or mental illness except as specified in Sections 8.
- Services related to your convicted commission of a crime or participation in an illegal activity.
- Services rendered while you are in the custody of law enforcement.

## **9.10 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 a lay-midwife and home births; and
- Infertility treatment including prescription drugs except for the diagnosis of infertility and in-vitro fertilization as described in this document.

## **9.11 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.

### **9.12 Services Covered Through Other Programs**

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

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

### **9.13 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.

### **9.14 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



**Customer Service**

800-658-8878

TTY for the hearing impaired: 800-649-3777

8:00 a.m. to 5:30 p.m. Monday through Friday

**Please address inquiries to:**

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