

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 ensuring coverage for your benefits under GradCare.

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

Blue Care Network
MC A02A
26255 American Drive
Southfield, MI 48034
800-662-6667
<https://www.bcbsm.com/>

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 is when a provider bills you for the difference between their charge for a Covered Service and the Approved Amount. A BCN Participating Provider may not balance bill you for Covered Services.

Benefit is a covered health care service that your plan helps pay for 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 legal document that describes the rights and responsibilities of both you and BCN.

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 BCN Approved Amount that you owe after you pay any Deductible. This amount is determined based on the Approved Amount at the time the claims are processed or reprocessed. Your Coinsurance is not altered by 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 owe for certain Covered Services usually when you receive the service. Your Copay can be amended 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. The Copay applies toward the Out-of-Pocket Maximum.

Cost Sharing (Deductible, Copayment or Coinsurance) is the portion of the health care costs you may owe as defined in this Certificate and 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 Member 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 owe for health care services before we pay. Payments made toward your Deductible are based on the Approved Amount at the time the claims are processed or reprocessed. 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.

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

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

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

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

Facility is a hospital, clinic, 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.

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

General Provisions 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 or quality of care that you submit to BCN. For a more detailed description of the Grievance process, refer to Section 3.5.

Group is the University of Michigan.

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

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

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.

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

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

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.)

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

Medical Necessity or Medically Necessary services are health care services provided to a Member according to evidence-based clinical practice guidelines (proven to be safe and effective based on current research) for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, condition, disease or its symptoms, and that are:

- Rendered in accordance with generally accepted standard of medical practice. "Generally accepted standards of practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury, condition or disease or its 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, condition 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 and outside of the GradCare Service Area. 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 with a BCN Participating Provider or BCN select on-demand virtual care vendor. 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.

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

Participating Provider is an individual Provider, Facility or other health care entity, which is contracted and credentialed with BCN and within the GradCare Service Area 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 (PCP) directs your care to a Referral Physician (Specialist) prior to a specified Service or treatment plan. The PCP coordinates the Referral and any necessary BCN Preauthorization.

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

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

Primary Care Physician (PCP) is a Level 1 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

Principally Supported Child is an individual less than 26 years of age for whom principal financial support is provided by the Subscriber in accordance with Internal Revenue Service standards, and who has met the eligibility standards for at least six full months prior to applying for Coverage. A Principally Supported Child must meet the requirements stated in Section 1.

NOTE: A Principally Supported Child is not the same as a Dependent Child.

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

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- 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)
- Licensed Genetic Counselors (LGC)
- Other providers as identified by BCN

Referral is a recommendation by your PCP for you to receive specialized care from a specialist or a Facility.

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. The majority of our Participating Providers are located in the Service Area.

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

Skilled care services must be:

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

- complex wound care

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

Subscriber is the eligible 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 for more about laws that protect you from Surprise Billing.

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

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

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

Table of Contents

<i>Topic</i>	<i>Page</i>
Definitions	iii
CHAPTER 1 - GENERAL PROVISIONS	15
SECTION 1: ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE	15
1.1 Eligibility	15
1.2 Additional Eligibility of Guidelines	15
SECTION 2: OTHER PARTY LIABILITY	17
2.1 Nonduplication	17
2.2 Workers' Compensation Claims and No-Fault Auto	17
2.3 Coordination of Benefits (COB)	18
2.4 Subrogation and Reimbursement	21
SECTION 3: MEMBER RIGHTS AND RESPONSIBILITIES	23
3.1 Confidentiality of Health Care Records	23
3.2 Inspection of Medical Records	23
3.3 Primary Care Physician	23
3.4 Grievance Procedure	24
3.5 Additional Member Responsibilities	27
SECTION 4: FORMS, IDENTIFICATION CARDS, RECORDS AND CLAIMS	27
4.1 Forms and Enrollment	27
4.2 Identification Card	27
4.3 Misuse of Identification Card	28
4.4 Enrollment Records	28
4.5 Authorization to Receive Information	28
4.6 Member Reimbursement	28
SECTION 5: TERMINATION OF COVERAGE	29
5.1 Termination of Coverage	29
5.2 Termination for Nonpayment	29
5.3 Termination of a Member's Coverage	29
5.4 Extension of Benefits	30
SECTION 6: CONTINUATION COVERAGE	30
6.1 Loss Because of Eligibility Change	30
6.2 COBRA Coverage	31
SECTION 7: GENERAL PROVISIONS	31
7.1 Notice	31
7.2 Change of Address	31
7.3 Headings	32
7.4 Execution of Contract of Coverage	32
7.5 Assignment	32
7.6 BCN	32

7.7	Litigation.....	32
7.8	Your Contract.....	32
7.9	Reliance on Verbal Communications and Waiver by Agents.....	33
7.10	Riders.....	33
7.11	Major Disasters.....	33
7.12	Obtaining Additional Information.....	33
7.13	Right to Interpret Contract.....	34
7.14	Inter-Plan Program.....	34
7.15	Unlicensed and Unauthorized Providers.....	38
7.16	Special Programs.....	38
7.17	Surprise Billing.....	38
7.18	Experimental Treatment.....	39

CHAPTER 2 - YOUR BENEFITS42

SECTION 8: YOUR BENEFITS.....42

8.1	Cost Sharing.....	43
8.2	Medical Professional Services.....	45
8.3	Continuity of Care for Professional and Facility Services.....	47
8.4	Inpatient Hospital (Facility) Services.....	49
8.5	Outpatient Services.....	51
8.6	Emergency and Urgent Care.....	51
8.7	Ambulance.....	53
8.8	Preventive and Early Detection Services.....	55
8.9	Reproductive Care and Family Planning Services.....	58
8.10	Skilled Nursing Facility Services.....	62
8.11	Home Health Care Services.....	62
8.12	Hospice Care.....	63
8.13	Home Infusion Therapy Services.....	64
8.14	Behavioral Health Services.....	65
8.15	Autism Spectrum Disorder.....	68
8.16	Outpatient Rehabilitation.....	71
8.17	Diabetic Supplies and Durable Medical Equipment.....	72
8.18	Prosthetics and Orthotics.....	74
8.19	Organ and Tissue Transplants.....	76
8.20	Reconstructive Surgery.....	77
8.21	Oral Surgery.....	78
8.22	Temporomandibular Joint Syndrome (TMJ) Treatment.....	78
8.23	Orthognathic Surgery.....	79
8.24	Weight Reduction Procedures.....	79
8.25	Gender Affirming Care.....	80
8.26	Hearing Aids.....	82
8.27	Prescription Drugs and Supplies.....	82
8.28	Clinical Trials.....	84

SECTION 9: EXCLUSIONS AND LIMITATIONS.....87

9.1	Facility Admission Prior to Effective Date.....	87
9.2	Services That Are Not Medically Necessary.....	87
9.3	Non covered Services.....	87

9.4	Cosmetic Surgery	88
9.5	Prescription Drugs	88
9.6	Military Care	89
9.7	Custodial Care.....	89
9.8	Comfort and Convenience Items	89
9.9	Court Related Services	89
9.10	Elective Procedures.....	89
9.11	Dental Services	89
9.12	Services Covered Through Other Programs	90
9.13	Alternate Services.....	90
9.14	Vision Services.....	90

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. Certain requirements depend on whether you are one of the following:

- Group Subscriber
- Family Dependent
- Dependent under a Qualified Medical Child Support Order
- Principally Supported Child

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 1 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

IMPORTANT NOTICE

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

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

It is your responsibility to provide complete and accurate information requested by us to administer Section 2. Failure to provide requested information, including information about other Coverage, may result in denial of claims. If claims are denied due to your failure to update this information, the service will be considered a noncovered benefit and you may be responsible for the full amount of your provider's charges.

2.1 Non-Duplication

- BCN Coverage provides you with benefits for health care services as described in this Certificate.
- BCN Coverage does not duplicate benefits or pay more for Covered Services than the Approved Amount.
- BCN does not allow "double-dipping," meaning that the Member and provider is not eligible to be paid by both BCN and another health plan or another insurance policy. This includes no duplicate benefits paid for no-fault auto related claims.
- This is a coordinated Certificate, meaning Coverage described in this Certificate 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.

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

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

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

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

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

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

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

Order of Benefit Payments

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) The plan covering the custodial parent.

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

(III) The plan covering the noncustodial parent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Length of Time Covered under a Plan

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

Plan Inability to Agree on Order of Benefits

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

Amount to be Paid by the Secondary Plan

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

Amount to be Paid by the Secondary Plan

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

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

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

2.4 Subrogation and Reimbursement

Subrogation is the assertion by BCN of your right, or the rights of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration

from another person, insurance company or organization.

Reimbursement 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 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 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 also may obtain a copy at any time by contacting BCN at the number provided on your ID card.

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

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

Definitions

Adverse Benefit Determination - means any of the following:

- A request for a benefit, on application of any utilization review technique, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit

YOUR BENEFITS

- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination of a covered person's eligibility for coverage.
- A determination that Surprise Billing protections are not applicable or the improper application of those protections, including the calculation of the applicable cost-share.
- A prospective or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- A rescission of coverage determination
- Failure to respond in a timely manner to request for a determination

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

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

Step One

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

Appeals and Grievance Unit
Blue Care Network
P. O. Box 44200
Detroit, MI 48244-0191
Fax 866-522-7345

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

The individuals who review the first-level grievance are not the same individuals involved in the initial decision. If your grievance is denied, BCN will send you a written explanation of the reasons for denial and the next steps in the process. If the grievance is about a clinical issue, we'll send it for review to an independent medical consultant in the same or similar specialty as the doctor who provided the service.

Step Two: Review by BCN Grievance Panel

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

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

External Review by an Independent Review Organization

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

Mail: Appeals and Grievance Unit, Blue Care Network
P.O. Box 44200
Detroit, MI 48244-0191
Fax: 1-866-522-7345

External Review by the Department of Insurance and Financial Services

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

Mail: P.O. Box 30220
Lansing, MI 48909-7720

Personal delivery: 530 W. Allegan Street, 7th floor
Lansing, MI 48933-1070

Phone: 1-877-999-6442

Fax: 517-284-8838

Email: DIFS-HealthAppeal@michigan.gov

Online: difs.state.mi.us/Complaints/ExternalReview.aspx
(Blue Care Network doesn't control this website and isn't responsible for its content.)

Expedited review

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

You, your doctor or someone acting on your behalf can initiate an expedited review by calling Customer Service number on the back of your BCN member ID card.

We will decide within 72 hours of receiving both your grievance and your physician's confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days. If we fail to provide you with our final determination in a timely fashion

or we deny your request, you may request an expedited external review from DIFS within 10 calendar days of receiving our final determination. In some instances, we may waive the requirement to exhaust our internal grievance process.

3.5 Additional Member Responsibilities

You have the responsibility to 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 Benefits, 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 visiting <https://www.bcbsm.com/>. Information regarding how to obtain a new ID

card is on our website.

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, you may request reimbursement for those Services. Proof of payment must show exactly what Services were received including diagnosis, procedure codes, date and place of Service. A billing statement that shows only the amount due is not sufficient.

Additional information on how to submit a claim and the and the Reimbursement Form is available at <https://www.bcbsm.com/> You may submit your itemized medical bills electronically through your Member online account or mail to the address below.

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

NOTE: Proof of payment must be submitted within 12 months of the date of service. Claims submitted 12 months after the date of service will not be paid.

Section 5: Termination of Coverage

5.1 Termination of Coverage

This Certificate and the contract between the Group and BCN will continue in effect for the period of time the Administrative Service Contract (ASC) remains in effect. The ASC and Coverage continue from year to year, subject to the rights of the Group, Group Health Plan and BCN to terminate the ASC. Coverage for Members will terminate on the date the ASC is terminated as permitted by law.

BCN will cooperate with the Group to arrange for continuing care of Members who are hospitalized on the termination date.

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's Cost Sharing

BCN may terminate Coverage under the following conditions:

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

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

5.3 Termination of a Member's Coverage

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
- You become eligible for other coverage

Section 6: 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 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, 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
- 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 Your Contract

Your contract consists of the following:

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

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

- Adjust premiums based on genetic information
- Require genetic testing

- Collect genetic information from an individual at any time for underwriting purposes

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

7.9 Reliance on Verbal Communications and Waiver by Agents

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

7.10 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.

7.11 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
- War
- Riot
- Civil insurrection
- Labor disputes not within the control of BCN

7.12 Obtaining Additional Information

The following information is available:

- The current provider network in your Service Area
- The professional credentials of the health care providers who are Participating Providers, 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
- Information about the financial relationships between BCN and a Participating Provider
- Preauthorization requirements and any limitations, restrictions or exclusions on services, Benefits or Providers

You can obtain the information through these sources:

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

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

7.13 Right to Interpret Contract

During claims processing and internal grievances, BCN reserves the right to interpret and administer the terms of this Certificate and any Riders that amend this Certificate. The adverse decisions regarding claims processing and grievances are subject to your right to appeal.

7.14 Inter-Plan Program

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 the Inter-Plan Programs. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

Overview

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

Typically, when accessing care outside the geographic area BCN serves, you obtain care from healthcare providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some

instances, you may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement (“nonparticipating providers”) with the Host Blue. BCN remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

Inter-Plan Programs Eligibility – Claim Types

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

A. Inter-Plan Programs

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

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

Liability Calculation Method Per Claim

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

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

- (i) Actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- (ii) Estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse

recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

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

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

B. Nonparticipating Providers Outside of the BCN Service Area

1. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of the BCN Service Area by nonparticipating providers, the amount(s) you pay for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCN will make for Out-of-Area 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: “domestic Service Area”), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Healthcare Services. The Blue Cross Blue Shield Global® Core is unlike the Inter-Plan Programs available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if you contact the 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 domestic Service Area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Healthcare Services.

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

When you pay for Covered Services outside the domestic Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider’s itemized bill(s) to the 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 <https://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.

7.15 Unlicensed and Unauthorized Providers

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

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

7.16 Special Programs

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

7.17 Surprise Billing

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

- Covered Emergency Services at a Participating or a Non-Participating Facility
- Covered Non-Emergency Services provided by Non-Participating Providers in the following Participating Facilities: Hospitals, Critical Access Hospitals, Hospital Outpatient Departments, and Ambulatory Surgical Centers.
 - You can waive Surprise Billing Protections if you sign a notice and consent form.

- Certain “ancillary” providers are not allowed to ask you to waive your Surprise Billing Protections. These include anesthesiologists, pathologists, emergency medicine providers, radiologists, neonatologists, hospitalists, and surgical assistants.
- Covered Air Ambulance Services

NOTE: The surprise billing provision does not apply to Groups that are designated as ‘Retiree Only’ and are exempt from the Affordable Care Act requirements. Contact your benefit administrator to determine if your plan is Retiree Only.

7.18 Experimental Treatment

We do not pay for:

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

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

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

How BCN Determines if a Treatment is Experimental

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

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

How BCN Determines if a Drug is Experimental

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

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

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

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

NOTE: The BCN Medical Director may consider other sources

Coverage

We do cover experimental treatment and its related services including drugs when all of the following are met:

- BCN considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for)
- The services related to the experimental treatment are covered under your Certificate when they are related to conventional treatment.

YOUR BENEFITS

- The experimental treatment and related services are provided during a BCN-approved clinical trial (check with your provider to determine whether a clinical trial is approved by BCN), or the related services are routine patient costs that are covered under “Clinical Trials” section.

Limitations and Exclusions

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

Chapter 2 - Your Benefits

Section 8: Your Benefits

Important Information

This Certificate 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 and all attached Riders carefully.

- 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, and 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 your Member account at <https://www.bcbsm.com/>
 - Disease management
 - Prevention
 - Wellness
 - Care management services

For an updated list of Services that require Preauthorization, contact Customer Service at the number shown on the back of on your BCN ID card or by visiting <https://www.bcbsm.com/priorauth>

8.1 Cost Sharing

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 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 apply towards the Out-of-Pocket Maximum.

The 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 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 Maximums

You have an Annual Copay Maximums.

Outpatient Behavioral Health

This maximum applies to all three levels combined for Outpatient Mental Health and Outpatient Substance Use Disorder office visits. The Copay Maximum is the most you will pay toward Outpatient Mental Health and Substance Use Disorder office visits. Once you reach the maximum, you will not pay Copays for the remainder of the year.

- \$450 per Member
- \$900 per Family (when 2 or more Members are covered under the same contract)

Physical Therapy

This maximum applies to all three levels combined for physical therapy visits. The Copay Maximum is the most you will pay toward physical therapy visits. Once you reach the maximum, you will not pay Copays 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)
 - BCN Participating OB/GYN
 - Referral Physician
 - Online Visit
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 services delivered virtually are considered Online Visits, but may be considered Telemedicine. Telemedicine services will be subject to the applicable Cost Share associated with the services provided.

Online Visit exclusions include but are not limited to

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

NOTE: See Preventive and Early Detection Services and Outpatient Services sections for further information about office visits.

- 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 Participating 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 the Home Care section.

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, Skilled Nursing Facility, Inpatient Rehabilitation center, or Inpatient Hospital at Home admission and billed by a physician when 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 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 and related office visits

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

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

NOTE: An affiliated immunization pharmacy can be found through the Find Care option through your BCBSM secured member account. Medical evaluation by a pharmacist will apply the Primary Care Physician office visit Cost Share as designated by your plan.

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 provider (physician or Facility) may continue treating you.

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

Provider Requirements

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

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

days may be extended if agreed by BCN and the provider.

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

Complex Medical Conditions

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

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

Coverage

If the former Participating Provider (including your Primary Care Physician) agrees you are a continuing care patient and meets the “Provider Requirements” listed above, BCN will continue to provide coverage for the Covered Services when provided for an ongoing course of treatment for Medical Conditions 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 described below:

You have up to 90 days of continued coverage for certain complex medical conditions that qualify you as a continuing care patient. The 90 days may be extended if agreed by BCN and the provider.

Complex Medical Conditions

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

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

Coverage

Coverage will be provided for Covered Services for an ongoing course of treatment, subject to 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) or Hospital at Home 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 gestational parent is covered for no less than the following length of stay in a hospital in connection with childbirth except as excluded under Section 9.

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

Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. BCN

Preauthorization is not required for the minimum hospital stay.

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
- 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 Member's attending physician
- Routine Care during the newborn's eligible hospital stay

The baby must be eligible for coverage and must be added to your contract within the eligibility timeframe set by 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 the Inpatient Professional Services section for 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 - Whether a condition is a “Medical Emergency” does not depend on a particular diagnosis. Instead, it is based on 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 Member, 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. Admission to the hospital after a Medical Emergency has been stabilized requires Authorization by BCN. However, Prior Authorization is not required for you to obtain Emergency Services.

Emergency Services include professional and related ancillary services and Emergency Services provided in an Urgent Care Center, Hospital Emergency room, or independent freestanding Emergency departments. Emergency Services are covered regardless of whether the provider or Facility is Participating.

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

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

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. If you refuse to be transferred, you may be required to sign a notice and consent form by the Non-Participating Hospital to continue receiving services. If you sign this form, all related non-Emergency Covered Services will not be covered from the date when the form is signed.

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. (See the Inter-Plan Program section for additional information.)

When Services are rendered by a Non-Participating Provider, we pay a rate based on the requirements of state and federal laws.

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

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 Member's home
- Other facilities

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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

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

- The service must be Medically Necessary. Any other means of transport would endanger the Member's health or life
- 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
- Non-Emergent air ambulance services must be approved before they occur. If they are not Preauthorized, they will be considered a noncovered benefit and you may have to pay the entire cost. It is important to make sure your provider gets approval before you receive services.
- 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:
 - 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**
 We follow PPACA guidelines consistent with the HRSA-Supported Women's Preventive Services Guidelines for the following services
 - Gynecological (well woman) examinations including routine pap smear
 - Screening mammography – One per Member per Calendar Year to screen for breast cancer
 - Additional breast cancer screening services, such as an ultrasound, may be required to address findings from the initial screening mammography. Each of the additional services are covered as preventive if received within 12

months of a screening mammography but not more than one per year.

- Screening for sexually transmitted diseases; HIV counseling and screening
- Contraceptive counseling and methods including measurement, fittings, insertion, removal, administration and management of contraceptive care as required by PPACA and consistent with HRSA-Supported Women’s Preventive Services Guidelines. FDA approved contraceptive methods include:
 - Contraceptive devices and appliances; such as intrauterine devices (IUDs)
 - Implantable and injected drugs such as Depo-Provera, and diaphragms
 - Contraceptive mobile app; one annual membership (12 consecutive months) per Member
 - When you purchase a yearly subscription for an FDA-approved contraceptive mobile app, log into your Member account at <https://www.bcbsm.com/> to find and fill out a reimbursement form. Submit the form along with your receipt for reimbursement. BCN will reimburse you up to charge for your yearly subscription.
- Routine preventive prenatal and postnatal office visits
- Maternity counseling for the promotion and support of breast-feeding, prenatal vitamin counseling, and alternative fertility awareness methods
- Breast pump and associated supplies needed to support breast-feeding covered only when Preauthorized and obtained from a Participating Durable Medical Equipment provider and as mandated by law. (See Durable Medical Equipment section for limitations and exclusions)
- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening
- Screening for gestational diabetes
- Screening for osteoporosis to prevent fractures
- Genetic counseling and BRCA testing, if appropriate, for Members whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes
- Screening and counseling for intimate partners and domestic violence
- Sterilization procedures for Members with female reproductive organs such as tubal ligation and related charges associated with the procedure (anesthesia, labs, ect.)
- **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

YOUR BENEFITS

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

We cover reproductive care and family planning. This benefit includes:

- Infertility
- Fertility Preservation
- Voluntary sterilization
- Elective Abortion
- 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 aged 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

In-vitro benefit limitations include:

- Single embryo transfer available for women up to age 35*;
- Single or double embryo transfer available for women age 35 through 42 years 364 days*
- IVF service not covered for women over age 43;
- 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.

In-Vitro Fertilization	
<p>Level 1 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 Lifetime Maximum of \$20,000 per contract for all U-M plans combined. Once the Lifetime Maximum has been reached, IVF services are no longer covered under any U-M plan.</p> <p>NOTE: Diagnostic work-up, ultrasounds, counseling and labs already covered are excluded from the lifetime maximum.</p>
<p>Levels 2 and 3</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
- Sterilization of female or male reproductive organs ends coverage for IVF

- Coverage for a Member who is not medically infertile
- Storage or manipulation of eggs and sperm except as noted above
NOTE: Manipulation of sperm such as sperm washing is covered when associated with IVF for Members with infertility diagnosis
- Services for the partner in a couple who is not enrolled with BCN and does not have coverage for infertility services or has other coverage
- 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	
Level 1 Services must be rendered by the University of Michigan Health System; Center for Reproductive Medicine.	Covered 80%; 20% Coinsurance 20% Coinsurance applies to the Out of Pocket Maximum. Covered Fertility Preservation and IVF services are subject to a combined Lifetime Maximum of \$20,000 per contract. Once the Lifetime Maximum has been reached, 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.

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

Sterilization of Male Reproductive Organs

- 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

d) Abortion

Coverage includes medical and surgical abortions, including elective abortions as defined in accordance with locally accepted medical practice and to the extent allowed by local law.

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

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 biological 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 the home, a licensed hospice Facility, or in a Skilled Nursing Facility is covered.

Coverage for Hospice includes the following five levels:

Level 1-Routine Home Care consists of services provided to Members who are living at home and are not receiving continuous care. Routine home care includes such services as counseling, home health aides, and therapy. It covers home care services provided for less than 8 hours a day.

Level 2 - Continuous Home Care consists of nursing care provided to Members during crisis periods to manage acute medical symptoms, for a Member who wishes to stay at home. It covers home care services provided for a minimum of 8 hours a day.

Level 3 - Inpatient Respite Care consists of short-term inpatient services provided to allow your home care providers periods of relief. Respite is provided only on an intermittent, non-routine and occasional basis and usually not more than twice during the patient's time in hospice care. Respite care includes coverage for room and board.

Level 4 – General Inpatient Care consists of inpatient services for symptom control for family breakdown that can't be managed in less-intensive settings. This level of care is usually reserved for the active dying process. Care may be provided in an inpatient hospice unit, inpatient hospital, or a skilled nursing facility. Room and Board are covered while the member is receiving approved general inpatient hospice care, regardless of the location.

Level 5 - Nursing Home with Hospice Support consists of care provided in a nursing home to Members who are medically stable but unable to return home because of their need for assistance and the unavailability of a caregiver.

Coverage

- 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 Hospice Level 5 is required.

Limitations

- Level 5 Hospice as defined above has a limit of 45 lifetime days.

Cost Sharing

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 for Mental Health conditions that are in accordance with generally accepted standards of practice. Non-Emergency Mental Health Services may require Preauthorization by BCN. (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 a state-licensed Facility that allows for 24-hour domiciliary care and supervision for safety. The Facility provides continuous treatment by or under the supervision of a qualified professional 24/7 with the response time to the Facility in case of emergency within 60 minutes. Residential treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that will allow the individual to reintegrate into the community - It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long-term means of protecting others in the Member's usual living environment; and
- Not based on a preset number of days such as standardized program (i.e., "30-Day Treatment Program")
- The treatment is managed by a multidisciplinary treatment team and reviewed regularly with the Member and team at least once weekly.

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.

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.

Outpatient Mental Health services include individual, conjoint, family or group psychotherapy, psychiatric evaluation, counseling, medical testing and crisis intervention.

Coverage

Mental Health care is covered in either an Inpatient or Outpatient setting. To obtain Services call the mental health treatment 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 \$450 per member/ \$900 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.

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

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 to other services. 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.

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

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

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

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 to other services.

Coverage

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

To obtain Services call the Substance Use Disorder Treatment 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 \$450 per member/ \$900 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 Behavior Analysis, or ABA, means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct-observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

Evaluation must include a review of the Member's clinical history and examination of the Member. An evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening as needed.

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

Benefits

Services for the diagnosis and treatment of ASD are covered when performed by a BCN Participating Provider and Preauthorized by BCN.

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

Coverage

ABA for Line Therapy services are subject to the 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 are subject to the Level 1, Level 2 or Level 3 Office Visit Copayment as defined in this Certificate of Coverage.

Level 1 - \$25 Copayment per visit

YOUR BENEFITS

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 \$450 per member/ \$900 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 Therapy services 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

Services performed to treat ASD will not count toward benefit maximums defined in this Certificate of Coverage including, but not limited to, visit or treatment limits imposed on physical therapy, speech therapy or occupational therapy.

Limitations

Coverage is available subject to the following requirements:

- **Prior Authorization** - Level 1, Level 2 and Level 3 services must be approved for payment during BCN's Preauthorization Process. If Preauthorization is not obtained, rendered services will not be covered and the Member may be held responsible for payment for those services. Once the initial Preauthorization expires, a request for continued services will be authorized contingent on the Member demonstrating measurable improvement and therapeutic progress.
- **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 Participating Provider. If services are rendered by a Non-Panel provider, you are responsible for any amount charged that exceeds the Approved Amount.

Required Evaluation for ABA – In order to receive Preauthorization, the Member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech language specialist. Other Preauthorization requirements may also apply.

Exclusions include but are not limited to

- Any treatment that is not specifically covered in the Autism Spectrum Disorders section herein and that is considered experimental/investigational by, or is otherwise not approved by BCN including, but not limited to, sensory integration therapy and chelation therapy
- Treatment for conditions not covered under BCN medical policy

8.16 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: 60 visits per medical episode per calendar year for any combination of physical, occupational, and speech therapy visits.

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.

* A \$500 per member/ \$1,000 per contract annual copayment maximum applies to all three Levels combined for physical therapy. The Annual Copayment Maximum only applies to physical therapy Copays. Speech, occupational, cardiac or pulmonary rehabilitation visits do not apply toward the annual copay maximum.

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
- Services for conditions that are generally required to be provided through publicly supported programs, public agencies or schools.
- Vocational rehabilitation

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

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 that are self-correcting and not severe

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 combined. 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 combined. 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 (Select insulin pumps are covered under your U-M pharmacy benefit)
- Diabetic shoes and inserts

NOTE: Continuous Glucose monitors (CGMs) and associated supplies are covered only under your U-M pharmacy benefit and not this medical Certificate of Coverage.

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 meet Medical Necessity and may require Prior Authorization 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,
- Appropriate for home use
- Obtained from a BCN-Participating Provider
- Prescribed by your Primary Care Physician or a Participating Provider
- 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.
- 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 and associated supplies are covered when Medically Necessary and obtained from a Participating Provider. (See Section 8.8 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 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.

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:

- 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. Your provider approves the

- Service and must notify BCN prior to the procedure taking place.
- 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 Gender Affirming Care

Gender Dysphoria

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

Gender Affirming Services

A collection of Services that are used to treat Gender Dysphoria. These Services must be considered Medically Necessary to be covered and may include:

- Hormone treatment (covered with separate criteria under the UM pharmacy benefit)
- Counseling and psychiatric services (refer to the Behavioral Health Services section)
- Voice and communication services (refer to the Outpatient Rehabilitation section)
- Hair removal (face and neck)
- Surgery

Gender Affirming Surgery

Covered Services are limited to:

- Genitalia reconstruction
- Mastectomy — (surgical removal of the breast)
- Augmentation mammoplasty (implants)
- Thyroid reduction chondroplasty (tracheal shave)
- Facial feminization
- Facial masculinization

Gender Affirming surgery must meet Medical Necessity criteria as determined by BCN medical policy and be Preauthorized by the provider and BCN.

Gender Affirming surgery must meet all of the following criteria:

- The member is at least 18 years of age
- The member has been diagnosed with gender dysphoria

YOUR BENEFITS

- Gender dysphoria is marked and sustained
- The member has capacity to make fully informed decisions and consent for treatment
- One letter of assessment by a qualified health care provider
- Other possible causes of apparent gender incongruence have been identified and excluded
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed
- The gender identity should be present for at least 12 months

Additional criteria may apply depending on the type of surgery, including but not limited to:

- The member is stable on their gender affirming hormonal treatment regime for at least 12 months, unless a rationale is provided by the provider that indicates that hormone treatment is either contraindicated or not necessary for the member's clinical situation
- The member has a consistent stable gender identity that is well documented by their treating providers and when possible, lives as their affirmed gender in places where it is safe to do so
- Existing facial appearance demonstrates significant variation from normal appearance for the experienced gender
- The procedure directly addresses variation from normal appearance for the experienced gender

Facial Hair Removal

Facial hair removal (face and neck) must meet all of the Medical Necessity criteria as indicated below. Prior Authorization not required when performed by a Participating Provider. Non-Participating Providers require Prior Authorization. The treating physician must contact BCN for Prior Authorization.

- The member is at least 18 years of age
- The member has been diagnosed with gender dysphoria
- Gender dysphoria is marked and sustained
- The member has capacity to make fully informed decisions and consent for treatment
- One letter of assessment by a qualified health care professional, as defined in BCN Medical Policy
- Other possible causes of apparent gender incongruence have been identified and excluded
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming medical treatments have been assessed
- The gender identity should be present for at least 12 months

NOTE: When hair removal is provided by a Non-Participating Provider, BCN will reimburse you directly for Covered Services. Log into your BCBSM.com member account to find and fill out a reimbursement form. Submit the form along with:

- Copy of approval letter from BCN
- Receipt that shows proof of payment and date paid
- Invoice from the treating provider which shows dates of service and provider information

Contact BCN customer service for additional questions on Prior Authorization or reimbursement for Non-Participating Providers.

Coverage

Facial hair removal is covered in full. Services can be rendered by a BCN Participating Provider or a Non-Participating Provider located in Michigan including BCN Participating Providers outside of the GradCare Service Area.

Exclusions include but are not limited to

- Reversal of physical or functional outcomes due to gender affirming services.
- Reversal of surgical procedures performed for gender affirming services.
- Procedures that are primarily cosmetic and not reconstructive and/or not medically necessary as defined by BCN Medical Policy include, but not limited to:
 - Rhytidectomy (face lift)
 - Otoplasty (ear procedures)
 - Lip enhancement (filler, vermillion augmentation)
 - Hair transplantation/hairline repositioning
 - Dermabrasion /chemical peel
 - Collagen/injectable dermal fillers
 - Liposuction
 - Abdominoplasty

8.26 Hearing Aids

For more information on your hearing benefit, please see your hearing rider.

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

Select injectable drugs in certain categories and drugs that are not primarily intended to be administered by a health professional are covered only if you 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
- Self-administered drugs as defined by the FDA are not covered under your medical benefit unless approved by BCN.

d) Cellular and Gene Therapy

Definitions

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

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

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

Coverage

We cover the following Cellular and Gene Therapies:

- For cancer indications
NOTE: This Certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.
- For non-cancer indications that have been proven to be effective, as determined by BCN. BCN considers a Cellular and Gene Therapy to be effective to treat a condition if the following are true:
 - The drug has full FDA approval that was not obtained under the FDA's Accelerated Approval Pathway; and
 - The drug met all of its Primary Endpoint(s) in its pivotal trials; or
 - If confirmatory trials were required, the drug met its Primary Endpoint(s) in its confirmatory trial(s)

Exclusions include but are not limited to:

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

e) Outpatient Prescription Drugs

We do not cover 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.

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

Coverage

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

YOUR BENEFITS

- 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).
- Treatment is provided as conventional treatment.
- The Services related to the Experimental treatment are covered under this Certificate of Coverage and associated Riders when they are related to conventional treatment.
- The Experimental treatment and related Services are provided during BCN-approved clinical trial (check with your provider to determine whether a Clinical Trial is approved by BCN).

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

Limitations and exclusions include but are not limited to

- The Experimental or Investigational item, device or Service itself
- Experimental treatment or Services related to Experimental treatment , except as explained under “Coverage” above
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Routine patient costs for Phase I clinical trials whose primary purpose is not for therapeutic intent (e.g., prolongation of life, shrinkage of tumor, or improved quality of life, even in absence of cure or dramatic improvement of a condition)
- Administrative costs related to Experimental treatment or for research management
- Coverage for Services not otherwise covered under this Certificate of Coverage
- Drugs or devices provided to you during a BCN approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the Member’s condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device
- Complications resulting from an Experimental procedure
- Use of transition technologies as a routine service in an Approved Clinical Trial such as cellular or gene therapies that have not been FDA approved for those indications

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 BCN 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.
- Programs associated with disorders of consciousness for individuals in any of the following states of consciousness including, but not limited to, coma, cognitive motor disassociation, vegetative/unresponsive wakefulness or minimally conscious state using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation.

9.4 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:

Blue Care Network

PO Box 68767

Grand Rapids, MI 49516-8767