

**Michigan State University  
Graduate Assistant Plan**

**CERTIFICATE OF COVERAGE**  
**Blue Care Network**  
**A licensed third-party administrator**

This document describes the Benefits provided under your Coverage and may be amended at any time, upon mutual agreement between Michigan State University (“MSU”), Group Health Plan and Blue Care Network (“BCN”).

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

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

The General Provisions and Your Benefits chapters describe the Benefits provided under your Coverage in accordance with the Administrative Service Agreement (“ASC”).

By choosing to enroll as a BCN Member, you agree to abide by the rules as stated in the General Provisions and Your Benefits chapters of this book.

Please read these documents carefully and keep them with your personal records for future reference. MSU reserves the right to interpret and resolve conflicts between any statements in this Certificate of Coverage that conflict with MSU booklets, summaries or other benefit related documents.

## Definitions

These definitions will help you understand the terms used in this Certificate. They apply to the entire Certificate. Other terms are defined in subsequent sections as necessary. In addition to these terms, use of 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 that may be enrolled as either a Subscriber or Dependent.

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

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

**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. Deductibles, Copayments and Coinsurance that may be required of you are subtracted from the Approved Amount before we make our payment.

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

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

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

**BCN Network Benefits** are Covered Health Services that are provided by a BCN Participating Provider or Facility. BCN Network Benefits are paid at a higher rate than Out-of-Network Benefits.

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

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

**Blue Care Network (BCN)** is a Michigan Health Maintenance Organization in which you are enrolled. **Certificate of Coverage** is this booklet that describes the Coverage available to you. The reference to Blue Care Network may include another entity or person Blue Care Network authorizes to act on its behalf.

**Chronic** is a disease or ailment that is not temporary or recurs frequently. Arthritis and heart disease, major depression and schizophrenia are examples of Chronic diseases.

**Cognitive Rehabilitation Therapy (“CRT”)** is the process of relearning Cognitive Skills that have been lost or altered as a result of damage to brain cells/chemistry. If skills cannot be relearned, then new ones have to be taught. CRT teaches us how to compensate for these lost cognitive functions.

**Cognitive Skills** are the core skills we use to think, read, learn, remember, reason, and pay attention.

Working together, they take incoming information and move it into the bank of knowledge we use every day at school, at work, and in life.

**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 an audit or recovery. Your Coinsurance is added or amended when an Amendment is attached. The Coinsurance applies to the Out-of-Pocket Maximum.

**Continuity of Care** refers to a Member's right to choose, in certain circumstances, to continue receiving services from a physician 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 (Copay)** is a fixed dollar amount you owe for certain Covered Services. The Copay is due at the time the Service is rendered. Copay amounts might be different for different health care services. For example, your Emergency Room Copay might be higher than your office visit Copay. Copays apply toward the Out-of-Pocket Maximum.

**Cosmetic Procedures** are procedures or services that change or improve appearance without significantly improving physiological function, as determined by BCN.

**Cost Sharing** (Deductible, Copayment or Coinsurance) is the portion of health care costs you owe as defined in this Certificate of Coverage and any attached Amendments. BCN pays the balance of the Allowed Amount for Covered Services.

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

**Coverage Period or Plan Year** is the period designated by MSU and BCN. It begins on the date as determined by MSU and BCN. Please check [www.hr.msu.edu](http://www.hr.msu.edu) for Coverage Period/Plan Year dates.

**Covered Services or Coverage** are those Medically Necessary services, drugs or supplies provided in accordance with and identified as payable under the terms of this Certificate of Coverage. The services must be ordered or performed by a 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 walking, getting in and out of bed, bathing, cooking, cleaning, dressing and taking medicine. Custodial Care can be provided safely and reasonably by people without professional skills or training. Custodial Care is not covered.

**Deductible** is the amount that you owe for health care services before BCN pays. 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. Your Deductible amount is added

or revised when an Amendment is attached. The Deductible does not apply to all services. The Deductible applies to the Out-of-Pocket Maximum.

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

- The use or prescription of a drug or device intended as a contraceptive;
- The intentional use of an instrument, drug or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert their death; or
- Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy

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

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

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

**Facility** is a Hospital, clinic, freestanding center, urgent care, dialysis center, etc. that provides specialized treatments devoted primarily to the diagnosis, treatment care or rehabilitation due to illness or injury.

**General Provisions** is Chapter 1. It describes the rules of your health care Coverage.

**Group** is Michigan State University (MSU).

**Group Health Plan** means the medical Benefits plan provided by MSU.

**Habilitative Services/devices** are health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at an expected age. These Services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient or Outpatient settings.

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

**In-Network Benefits** are Covered Health Services that are provided by a Participating Provider or Facility. In-Network Benefits are paid at a higher rate than Out-of-Network Benefits.

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

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

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

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

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

- Rendered in accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease or 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 or disease
- Not regarded as experimental by BCN
- Rendered in accordance with BCN Utilization Management Criteria.

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

**Mental Health Provider** is duly licensed and qualified to provide mental health services in a Hospital or other Facility in the state where treatment is received.

**MSU Health Team** is the multi-specialty medical practice comprised of teaching faculty from MSU's College of Medicine, College of Osteopathic Medicine, and College of Nursing. MSU Health Team offers primary and specialty health care services to the general public. It is comprised of approximately 200 physicians and nurse practitioners from 14 clinical departments as well as many allied health professionals.

**Non-Participating Provider** is an individual, Facility, or other health care entity not under contract with BCN. Non-Participating Providers must be appropriately licensed to perform the Covered Health Service provided. Non-Participating Providers are not listed in the BCN Provider Directory. Services provided by a Non-Participating Provider are subject to the Out-of-Network Benefits unless otherwise stated in this Certificate. If a specific service requires Prior Authorization and the authorization is not received from BCN, the Non-Participating Provider may bill you for the service and you will be responsible for the entire bill.

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

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

**Out-of-Network Benefits** are Covered Health Services that are provided by a Non-Participating Physician or other Non-Participating provider in an office or Facility. Out-of-Network Benefits apply higher Cost-Sharing than In-Network Benefits and may be subject to Balance Billing (unless otherwise noted).

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

**Participating or Participating Provider** means an individual Provider, Facility or other health care entity that is contracted and credentialed with BCN to provide you with Covered Services. The Participating Provider agrees 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.

**Pediatric Member** is a child ranging from date of birth up to 17 years of age. Pediatric Members are not eligible to be seen at SHS at Olin Health Center. Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of SHS at Olin Health Center.

**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 disease. Examples of Preventive Care include immunizations, health screenings, mammograms and colonoscopies.

**Primary Care Physician (PCP)** is Student Health Services (SHS) at Olin Health Center. You will be assigned an Olin Health Center physician who will provide and coordinate your medical health care including specialty Referrals and Hospital care.

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

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

**Referral** is required from MSU Student Health Services at Olin Health Center if you seek care from a BCN Network provider that is located within a 45 miles radius of Olin Health Center. Benefits will not be paid for care received from a BCN Network provider located within 45 miles of Olin Health Center without a Referral. You must begin treatment at Olin Health Center for Benefits to be paid. A Referral is required for each separate medical condition. A new Referral is needed each Plan Year for continuing treatment.

NOTE: Additional information is found in Section 8 Your Benefits-Important Information in this Certificate of Coverage.

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

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

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

**Rider** is an amendment to this Certificate that describes any changes (addition, modifications, deletion or revision) to Coverage. A Rider also applies or amends Cost Sharing and Benefit Maximums. to select Covered Services. When there is a conflict between the Certificate and a Rider, the Rider shall control over the Certificate.

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

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

**Service Area** is the geographic area in Michigan in which BCN does business. The majority of our BCN Providers are located in the Service Area.

**Skilled Care** means Services that:

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

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

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

**Student Health Services (SHS) at Olin Health Center** is the Michigan State University's primary on-campus health facility. Medical Services are provided by board-certified physicians and other certified medical professionals.

**Subscriber** is the eligible MSU student who has enrolled with Blue Care Network. This person is responsible for payment of Coverage premiums. This person is also referred to as the "Member".

**NOTE:** See Section 1 for eligibility requirements or contact the MSU Benefits office.

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

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

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



injury, or the onset of Acute or severe symptoms.

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

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# CHAPTER 1 - GENERAL PROVISIONS

## Section 1: Eligibility

### 1.1 Eligibility

Michigan State University (MSU) is responsible for determining eligibility. BCN does not make eligibility determinations, but updates its files to record eligibility information provided by MSU.

Please contact MSU Human Resources at (800)353-4434 or (517)353-4434 for eligibility information.

### 1.2 Additional Eligibility Guidelines

The following guidelines apply to all Members:

- **Medicare:** If you become eligible to enroll in Medicare, you will only be eligible for the Medicare complementary program **except** when Medicare is the secondary payer by law.
- **Change of Status:** You agree to notify Group Health Plan within 30 days of any change in eligibility status of you or any family dependents. When you are no longer eligible for Coverage, you are responsible for payment for any services or Benefits unless the services are covered under other health benefit plan or insurance.
- If you are admitted to a Hospital or Skilled Nursing Facility prior to the effective date of this Certificate of Coverage you will be covered for Inpatient care on the effective date of Coverage only if:
  - ✓ You have no continuing coverage under any other health Benefits contract, program or insurance;
  - ✓ BCN or BCN authorizes inpatient care as Medically Necessary upon notification of admission; and
  - ✓ Your medical management is transferred to your Primary Care Physician before or on the effective date.

## Section 2: Other Party Liability

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

- Are not Preauthorized by BCN; or
- Are not Covered Services under this Certificate of Coverage.

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

### 2.1 Non-duplication

- BCN Coverage provides you with Benefits for health care services as described in this Certificate of Coverage.
- BCN does not duplicate Benefits or pay more for Covered Health Services than the actual fees.
- Coverage described in this Certificate of Coverage will be reduced to the extent that the

services are available or payable by other health plans or policies under which you may be covered, whether or not you make a claim for the payment under such health plan or policy.

## **2.2 Auto Policy and Worker's Compensation Claims**

This Certificate of Coverage is a coordinated Certificate of Coverage. This means that for medical care needed as the result of an automobile accident, if the Member has a coordinated no-fault insurance policy, then BCN will assume primary liability for Covered Services. The no-fault automobile insurance would be secondary.

- If the Member has coverage through a non-coordinated (sometimes called a “full medical”) no-fault automobile insurance policy, then the automobile insurance will be considered the primary plan. BCN would pay Coverage under this Certificate of Coverage as the secondary plan.
- 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 of Coverage 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 the motorcycle insurance plan is primary. BCN would pay for Covered Services under this Certificate of Coverage as the secondary plan.
- If the motorcycle insurance does not provide medical coverage or if medical coverage is exhausted, then BCN will pay for Covered Services under this Certificate of Coverage as the primary plan. Members who ride a motorcycle without a helmet are required by Michigan State law to purchase medical coverage through their motorcycle insurance plan and BCN will pay secondary.
- Services and treatment for any work-related injury that are paid, payable or required to be provided under any workers' compensation program will not be paid under Coverage.
- If any such services are paid or provided by BCN, BCN has the right to seek reimbursement on behalf of the Group Health Plan from the other program, insurer or Member who has received reimbursement.
- Applicable BCN authorization and Coverage requirements must always be followed for auto or work-related injuries. Failure to follow applicable Preauthorization or Coverage requirements may leave you solely responsible for the cost of any services received.

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

After those benefits are determined, your BCN 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, and you may still have a remaining Member Liability after all plans have made payment.

## **2.4 Subrogation and Reimbursement**

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

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

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

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

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

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

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

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

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

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

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

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

**YOUR RESPONSIBILITIES:** In certain cases, BCN may have paid for health care services for you that were or should have been paid by another person, insurance company or organization. In these cases:

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

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

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

Your health care records will be kept confidential by BCN, its agents and the providers who treat you in accordance with state and federal privacy laws.

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

BCN agrees to keep this information confidential. Consistent with our Notice of Privacy Practice, information will be used and disclosed only as Preauthorized or as required by or as may be permissible under 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 BCN policy.

### **3.3 Primary Care Physician**

***Olin Health Center is your designated Primary Care Provider.***

Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of SHS



at Olin Health Center. 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 to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetric and gynecologic care. The Participating specialist, however, may be required to comply with certain BCN procedures, including obtaining Preauthorization for certain Services, following a pre-approved treatment plan, or procedures for making Referrals. The female Member retains the right to receive the obstetrical and/or gynecological Services directly from their Primary Care Physician.

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

If after reasonable efforts, you and the Primary Care Physician are unable to establish and maintain a satisfactory physician-patient relationship, you may be transferred to another Primary Care Physician. If a satisfactory physician-patient relationship cannot be established and maintained, you may be asked to disenroll upon 30 days written advance notice; all dependent family members will also be required to disenroll from Coverage. (See Section 5)

### **3.4 Refusal to Accept Treatment**

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

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

### **3.5 Complaint and Grievance Procedure**

If you have a complaint or grievance regarding any aspect of the services received, you must follow the Group Health Plan grievance procedure. You can find a copy of this procedure at <https://www.bcbsm.com/> or you can contact Customer Service who will provide you with a copy.

### **3.6 Additional Member Responsibilities**

You have the responsibility to:

- Read this Certificate of Coverage and all Group Health Plan documents.
- Call Customer Service at the number on the back of your BCN ID Card with any questions.
- Comply with the plans and instructions for care that you have agreed on with your practitioners.

- Provide, to the extent possible, complete and accurate information that BCN Providers need in order to provide you with care.
- Make and keep appointments for non-emergent medical care. Notify 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 MSU, BCN or BCN requests. You represent 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 Coverage upon 30 days written advance notice.

You have the right to appeal our decision to Rescind your Coverage by following the Complaint and Grievance procedure described in this Certificate of Coverage and online at <https://www.bcbsm.com/ImportantInfo>. Or, you can call Customer Service at the number provided on the back of your BCN 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 you are not entitled to receive Benefits, you 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 BCN ID card is also on our website.

### **4.3 Enrollment Records**

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

#### **4.4 Authorization to Receive Information**

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

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

#### **4.5 Member Reimbursement**

Your Coverage is designed to avoid the requirement that you pay a provider for Covered Services except for applicable Copayments, Coinsurance or Deductible. If, however, circumstances require you to pay a provider, ask us in writing to be reimbursed for those services. Written proof of payment must show exactly what services were received including diagnosis, CPT 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 Reimbursement Form is available at <https://www.bcbsm.com/>. Send your itemized medical bills promptly to us.

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

NOTE: Written 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 reimbursed.

## **Section 5: Termination of Coverage**

### **5.1 Termination of Group Coverage**

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

### **5.2 Termination for Nonpayment**

Nonpayment by Group

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

### **Nonpayment of Member Copayment, Coinsurance and Dependent Premium**

BCN may terminate Coverage under the following conditions:

- If you fail to pay Copayments or other fees within 90 days of their due date;
- If you do not make or comply with acceptable payment arrangements with the provider to correct the situation; or
- You fail to submit premium for Covered dependent within 31 days. NOTE: Any Covered Services incurred by the Covered dependent and paid by BCN after the date of last full payment will be charged, as permitted by law, to the individual Member.

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

### **5.3 Termination of a Member's Coverage**

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

- You no longer meet eligibility requirements.
- Coverage is cancelled for nonpayment.
- You misuse your Coverage
  - Misuse includes illegal or improper use of your Coverage such as:
    - Allowing an ineligible person to use your Coverage
    - Requesting payment for services you did not receive
- You fail to repay BCN for payments we made for services that were not a benefit under this Certificate. Subject to your rights under the appeal process
- You are satisfying a civil judgment in a case involving BCN
- You are repaying BCN funds you received illegally
- You are serving a criminal sentence for defrauding BCN
- Your group changes to a non-BCN/BCN health plan
- We no longer offer this coverage

**Rescission:** If you commit fraud that in any way affects your Coverage or make an intentional misrepresentation of a material fact to obtain, maintain or that otherwise affects your Coverage, BCN will consider you in breach of contract and, upon 30 days written advance notice, your membership may be Rescinded. 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
- Intentional misuse of the BCN system
- Knowingly providing inaccurate information regarding eligibility

You have the right to appeal our decision to Rescind your Coverage by following the BCN complaint and grievance procedure. You can find this procedure in your Certificate of Coverage, on our website at <https://www.bcbsm.com/> or you can contact Customer Service at 1-800-662-6667 who will provide you with a copy.

## **5.4 Extension of Benefits**

All rights to Benefits under Coverage end on the termination date except:

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

As permitted by law, this extension of Benefits will continue only for the condition being treated on the termination date, and only until any one of the following occurs:

- The Member is discharged;
- You become eligible for other coverage; or
- The Benefits exhausted prior to the end of the contract.

## **Section 6: Conversion and Continuation Coverage**

### **6.1 Loss Because of Eligibility Change**

If you continue to be entitled to receive Benefits under the Group Health Plan, but no longer meet MSU coverage eligibility requirements, you must transfer to an alternate benefit program offered by MSU, if any. Contact MSU Human Resources at (800)353-4434 or (517)353-4434 for additional information regarding continuation of coverage.

If no alternate benefit program is available, or if you are unable to meet any alternate benefit program eligibility requirements, you may apply for non-group coverage through Blue Care Network of Michigan, Inc. or Blue Cross Blue Shield of Michigan. Contact BCN Customer Service for information on non-group coverage.

### **6.2 COBRA Coverage**

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

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

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

1. You may apply and pay for group continuation coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
2. This coverage may continue for up to 18, 29 or 36 months depending on the reason for your initial ineligibility.
  - You are considered a Group Member for all purposes including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the

- extent that the federal law specifically allows continuation.
- Continuation coverage and all Benefits cease automatically for a Group Member under **any** of the following:
    - The period allowed by law expires.
    - Your employer no longer includes BCN Coverage as a part of its Group Health Plan.
    - You begin coverage under any other benefit program or health coverage plan (with some exceptions).
    - You become eligible for Medicare.
    - You do not pay for Coverage fully and on time.

## **Section 7: General Provisions**

### **7.1 Notice**

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

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

### **7.2 Change of Address**

You must update Membership records immediately when you change your address. Please notify MSU and BCN. You must live in the Service Area at least six months out of each Plan year.

### **7.3 Heading**

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

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

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

### **7.5 Assignment**

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

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

### **7.6 Blue Care Network**

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

## **7.7 Litigation**

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

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

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

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

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

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

## **7.9 Amendments**

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

## **7.10 Major Disasters**

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

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

- Complete or partial disruption of facilities
- Disability of a significant part of facility, BCN or BCN personnel
- War
- Riot
- Civil insurrection

- Labor disputes not within the control of BCN

### **7.11 Obtaining Additional Information**

The following information is available:

- The current provider network in your Service Area
- The professional credentials of our Participating Providers
- 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
- The financial relationships between BCN and a Participating Provider
- Preauthorization requirements and any limitations, restrictions or exclusions on Services, Benefits or Providers

You can obtain the information through these sources:

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

### **7.12 Right to Interpret Contract**

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

### **7.13 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

### **7.14 Special Programs**

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



We may terminate any special program based on:

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

### **7.15 Out of Area Services**

Services under this Certificate of Coverage are covered only in the state of Michigan with the exception of emergency or BCN Preauthorized Services.

If you receive Covered Services in another state, the claims will be processed through the BlueCard® Program, a Blue Cross® and Blue Shield® Association program. It does not expand your Coverage to include out-of-state providers. It defines the payment method used should an incidental out-of-state claim be incurred.

#### Overview

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

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

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

#### Inter-Plan Arrangements Eligibility – Claim Types

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

## A. BlueCard® Program

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

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

### Liability Calculation Method Per Claim

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

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

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

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

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

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

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

### **2. Exceptions**

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

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

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

### **General Information**

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

#### **D. Exclusions and Limitations**

This addendum will not apply if:

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

#### **E. General Information**

- If you have a Deductible, you will be responsible for payment of applicable Deductible for covered services at the time those services are received.
- Your Deductible, Coinsurance and Copayment requirements are based on your Certificate and Riders and remain the same regardless of which Host Blue processes your claim for services.
- Until further notice, all the terms, definitions, limitations, exclusions and conditions of your Certificate and related Riders remain unchanged.

For more information about Out of State Services go to <https://www.bcbsm.com/> or call Customer Service at the number shown on the back of your BCN ID card.

## 7.16 Surprise Billing

Federal (effective 1-1-2022) and Michigan state law require us to pay Non-Participating Providers certain rates for Covered Services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, you will only pay the Cost Share applicable to that service. The following situations are covered by the Surprise Billing laws:

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

## CHAPTER 2 - YOUR BENEFITS

### Section 8: Your Benefits

Michigan State University Student Health Services (SHS) at Olin Health Center is the University's primary on-campus health facility for MSU students and their spouses/partners. Medical Services are provided by board-certified physicians and other certified medical professionals.

Except for treatment of an Emergency Medical condition, covered Members are required to utilize SHS at Olin Health Center before seeking off-campus treatment.

You may receive care at SHS Olin Health Center with some out-of-pocket costs. For general information, please call (517)884-OLIN (6546) or visit the website at <http://olin.msu.edu>.

Pediatric Members are not eligible to be seen at SHS at Olin Health Center but will be assigned a BCN Network pediatrician within a 45-mile radius of SHS at Olin Health Center. Out-of-Network providers may see Pediatric Members. Selecting a BCN Network Provider is recommended to minimize your Out-of-Pocket costs.

The Services listed in this chapter are covered when Services are provided in accordance with the Certificate of Coverage requirements (including Referrals from SHS at Olin Health Center or other Participating Provider) and, when required, are Preauthorized or approved by BCN except in an Emergency.

### IMPORTANT INFORMATION

- Medical Services provided in accordance with the terms of this Certificate of Coverage are Covered Health Services only when they are Medically Necessary.
- Your health care Benefits are provided as a part of the Group Health Plan. BCN has contracted with MSU and Group Health Plan to administer your Coverage.

- As discussed in the introduction of this Certificate of Coverage, BCN has arranged with BCN to provide administrative services to support your Coverage, including customer service and responsibility for Preauthorizations for Services.
- The Services listed in this chapter are covered when Services are provided in accordance with Coverage and, when required, are Preauthorized or approved by BCN.
- Coverage is subject to the limitations and exclusions listed in this Chapter.
- You are responsible for Deductible, Copayments and/or Coinsurance for many of the Benefits listed. If you receive a Service that we do not cover, you will be required to pay for that Service.
- A Referral or Preauthorization is not a guarantee of payment. All claims are subject to a review of the diagnosis reported, verification of Medical Necessity, the availability of Benefits at the time the claim is processed, as well as the conditions, limitations, exclusions, maximums, Coinsurance, Copayments and Deductible under your Certificate of Coverage and Amendments.
- For an updated list of Services that require Preauthorization, contact Customer Service at the number provided on the back of your BCN ID card or by visiting <https://www.bcbsm.com/>; select *Approving Covered Services*.
- Additional programs and Services, which include but are not limited to, disease management, prevention, wellness, and care management services defined in your member account at <https://www.bcbsm.com/>

You can find more details in your member account at <https://www.bcbsm.com/>

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

This Plan allows you to choose where to receive your health care. You may obtain Covered Health Services directly from SHS at Olin Health Center allowing you to receive Olin Health Center Benefits, or you can choose to receive Covered Health Care Services from a BCN Network Participating Provider or from Out-of-Network Non-Participating Provider.

Michigan residents must have a BCN Primary Care Physician to provide or coordinate In-Network Covered Services.

***Student Health Services at Olin Health Center*** - refers to Benefits for select Medical Services provided at (i) SHS at Olin Health Center; or (ii) referred by SHS at Olin Health Center and performed by a BCN Network Participating Provider. SHS at Olin Health Center is your designated Primary Care Provider.

You must use the resources of Olin Health Center first where treatment will be rendered or a Referral issued. A Referral is required if you receive services from BCN Network providers located within 45 miles of Olin Health Center.

Benefits will not be paid for care received within 45 miles of Olin Health Center without a Referral (except treatment of an emergency condition, maternity or mental health). Referrals must be renewed each Plan Year for continuing treatment to be covered. A separate Referral is required for each diagnosed condition.

### Note to Dependent Children

Pediatric Members are not eligible to be seen at Olin Health Center. Pediatric Members will be assigned a BCN Network pediatrician within a 45-mile radius of Olin Health Center. However, Out-of-Network providers may see Pediatric Members. Referrals are not required for Services provided by BCN Network or Out-of-Network for all dependent children.

**BCN Network (Participating Providers)** – refers to Benefits for Services Referred by (i) SHS at Olin Health Center; or (ii) provided by a BCN Network Participating Provider. A Referral from Olin Health Center is not needed for Services provided by a BCN Network Participating Provider who is located outside of a 45-mile radius of Olin Health Center.

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. Benefits are payable for In-Network Covered Services that are:

- Provided or coordinated by your Primary Care Physician in the office, in the home or at a Participating Provider – either Inpatient or Outpatient – with any required Preauthorization
- Provided by a Participating Provider with any required Preauthorization, but without coordination with the Primary Care Physician
- Provided by a Non-Participating Provider when there is an insufficient number of Participating Providers for a specific provider specialty within the BCN provider network. The service must be Preauthorized by BCN for the in-network Cost Share to apply. If Prior Authorization is not received before you receive Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for paying the out-of-network Cost Sharing when received from a Non-Participating Provider.
- Emergency health services
- Urgent care center services
- Provided outside of Michigan utilizing the BlueCard Program (Section 9 Out of Area Services)

You are responsible for determining whether a provider is a BCN Network Participating Provider before obtaining Services. Unless otherwise specified in this Certificate of Coverage and the Surprise Billing section, Benefits will be paid based on the status of the provider as of the day the Services are received.

**Note:** If there is an insufficient number of Participating Providers for a specific provider specialty within the BCN Provider Network, you may obtain care from a Non-Participating Provider. The service must be Preauthorized by BCN for in-network Cost Share to apply. If Prior Authorization is not received before you receive Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for paying the out-of-network Cost-Sharing when received from a Non-Participating Provider.

**Out-of-Network Benefits (Non-Participating)** are generally paid at (i) a lower rate than Olin Health Center Benefits; or (ii) BCN Network Benefits; or (iii) may be excluded from Coverage. You may be responsible for the difference between the BCN Approved Amount and the Non-Participating Provider's charge. (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference).

Out-of-Network Benefits are payable for Covered Health Services that are:

- Provided within the State of Michigan by a Non-Participating Physician, other Non-Participating provider or at a Non-Participating Facility
- Preauthorized by BCN if Preauthorization is required. For a complete list of services requiring Preauthorization, contact customer service or visit <https://www.bcbsm.com/>; select *Approving Covered Services*. For these services, coordinate the authorization through BCN and the Non-Participating Provider.
- Provided outside of Michigan without utilizing the BlueCard Program (See Section 9 Out of Area Services)

NOTE: You must notify BCN before receiving certain Covered Health Services from an Out-of-Network Provider. Notification requirements are detailed below with respect to applicable Benefits.

### **Preauthorization**

Some Services provided in SHS at Olin Health Center, BCN Network and Out-of-Network require Preauthorization before they are covered. You are responsible for verifying Preauthorization for Services prior to obtaining the Service – except in an Emergency. Please refer to your BCN Member ID card for the appropriate telephone number to obtain Preauthorizations or if you have questions about Preauthorizations.

NOTE: Preauthorization is required for Inpatient, Outpatient Services or supplies.

Preauthorization is not a guarantee of payment.

## **8.2 Cost Sharing**

### **Deductible**

A Deductible is the amount you are responsible to pay before BCN will pay for Covered Health Services.

The Deductible will be applied to the Approved Amount for Covered Health Services. Charges paid by a Member in excess of the Approved Amount do not apply toward the Deductible.

In the case of two or more Members on a family Contract, the Deductible paid by all Members will be combined to satisfy the Contract (Family) Deductible. NOTE: An individual Member cannot contribute in excess of the individual Member Deductible toward the Contract (Family) Deductible. Once an individual meets their individual Deductible, that individual will not be responsible for any additional individual Deductible for the remainder of the Plan Year.



Per visit Copays or admission Copays do not apply towards satisfying the annual Deductible. Your Deductible renews each Plan Year. It does not carry over into the new year.

Deductible		
SHS at Olin Health Center	BCN Network	Out-of-Network
This option waives the Deductible for Services received at Olin Health Center.	\$125 per Member per Plan Year \$250 per contract per Plan Year <ul style="list-style-type: none"> <li>• Applies toward the Out-of-Pocket Maximum</li> <li>• Does not apply to Preventive Services</li> </ul>	\$250 per Member per Plan Year \$500 per contract per Plan Year <ul style="list-style-type: none"> <li>• Applies toward the Out-of-Pocket Maximum</li> <li>• Does not apply to Preventive Services</li> </ul>
If you use BCN Network and Out-of-Network Services, separate Deductible amounts apply. The Deductible for BCN Network and Out-of-Network is not combined to satisfy the Deductible limit.		

### **Copayment (Copay)**

You are responsible for fixed dollar Copays for many of the Benefits listed in this Certificate of Coverage. You are required to pay any Copays at the time you receive the Services. Copays count toward your Out-of-Pocket Maximum. Once your Out-of-Pocket Maximum is met, you will not be responsible for Copays for the remainder of the Plan Year.

### **Coinsurance**

You are responsible for a percentage of the Approved Amount (Coinsurance) for many of the Benefits listed in this Certificate of Coverage.

Your Coinsurance is dependent upon where you receive services from Olin Health Center, BCN Network, or Out-of-Network. Coinsurance amounts apply *after* you have met the Deductible. Coinsurance counts toward your Out-of-Pocket Maximum. Once you meet your Out-of-Pocket Maximum, you will not be responsible for Coinsurance for the remainder of the Plan Year.

Please refer to the specific section in this Certificate of Coverage to determine your Coinsurance responsibility.

### **Cost Sharing – Deductible, Coinsurance and Copay Calculation**

If you have a Coinsurance or a Copay for a particular Service as well as a Deductible, you will first be responsible for the payment of the Deductible. The Coinsurance or Copay 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 Copay have been paid.

NOTE: Any Cost Sharing met in Olin Health Center, BCN Network or Out-of-Network is not combined.

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

The Out-of-Pocket Maximum is the most you will pay for Covered Services under this Certificate of Coverage and any applicable Amendments per Plan Year. The Out-of-Pocket Maximum includes your medical Deductible, Copay and Coinsurance. Specific Services defined under this Certificate of Coverage apply to the Out-of-Pocket Maximum.

Once you reach the Out-of-Pocket Maximum, you will not pay Deductible, Copayments or Coinsurance for Covered Services for the remainder of the Plan Year. The following exceptions do not apply to the Out-of-Pocket Maximum.

- Any Premium or contributions paid toward the Premium
- Balance Billing and charges paid by you in excess of the Approved Amount
- Health Care this Plan does not cover
- Non-Referred or non-Preauthorized Services

Your Out-of-Pocket Maximum renews each Plan Year. It does not carry over to the new year.

Out-of-Pocket Maximum		
SHS at Olin Health Center	BCN Network	Out-of-Network
\$1,500 per Member \$3,000 per contract per Plan Year		\$2,300 per Member \$4,600 per contract per Plan Year
If you use a BCN Network or Out-of-Network Services, separate Out-of-Pocket Maximum amounts apply. The Out-of-Pocket Maximum for BCN Network and Out-of-Network is not combined to satisfy the Out-of-Pocket Maximum.		

**Note:** The Out-of-Pocket Maximum as defined in this Certificate of Coverage applies to medical Cost Sharing, which includes your pharmacy Cost Sharing.

### **Benefit Maximum**

Some of the Covered Services described in the Certificate of Coverage are covered for a limited number of days or visits per Plan Year. This is known as the Benefit Maximum. Once you have reached a maximum for a Covered Service, you will be responsible for the cost of the additional Services received during that Plan Year even when continued care may be Medically Necessary.

Some examples of Covered Services that have a Benefit Maximum include but are not limited to the following.

- Medical rehabilitation and habilitative services
- Spinal manipulation

### 8.3 Balance Bills

In-Network Benefits: You are not responsible for the difference between the Participating Provider's charge and the BCN Approved Amount.

Out-of-Network Benefits: You may be responsible for amounts charged by a Non-Participating Provider that exceed the Approved Amount (See Surprise Billing section for more information on circumstances where a provider is unable to charge you the difference).

### 8.4 Medical Professional Physician Services

**a) Office Visits** - including outpatient office site, hospital location or Primary Care Physician (PCP)

- OB/GYN for female Members
- Specialist physician
- Online Visit  
We cover Online Visits by a professional provider 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 professional provider 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.

**Note: See attached Rider for additional Online Visit Coverage and Cost Sharing.**

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

*Online Visit exclusions include but are not limited to*

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

Office Visit Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
<p>Olin Health Center is your assigned Primary Care Physician.</p> <p>Covered in full for first 3 visits of each school year for enrolled students only when provided at Olin Health Center</p> <p><b>\$15 Copay thereafter</b></p> <ul style="list-style-type: none"> <li>✓ Referral required from Olin for Services provided outside of Olin Health Center; within 45 miles radius</li> </ul>	<p>\$15 Copay after Deductible per visit</p> <ul style="list-style-type: none"> <li>✓ Referral required for services provided within 45 miles radius of Olin Health Center</li> <li>✓ Referral is not required if BCN Participating physician is beyond 45-mile radius of Olin Health Center</li> <li>✓ Preauthorization may be required</li> <li>✓ Women's health does not require a Referral from Olin Health Center</li> <li>✓ Deductible does not apply to Pediatric assigned PCP</li> </ul>	<p>Covered – 80% after Deductible</p> <p>20% Coinsurance of the Allowed Amount</p> <ul style="list-style-type: none"> <li>• Referral is not required from Olin Health Center</li> </ul>

**Note: See attached Rider for additional Online Visit Coverage and Cost Sharing.**

**b) Maternity Care** - including prenatal and post-natal visits when provided by your Primary Care Physician, OB/GYN or Certified Nurse Midwife.

Maternity Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
<p>Maternity Care Services are not provided at Olin Health Center - refer to BCN Network or Out-of-Network Benefits</p>	<p>Routine prenatal Services are covered in full.</p> <p>Postnatal Services - \$15 Copay after Deductible</p>	<p>Covered – 80% after Deductible</p> <p>20% Coinsurance of the Allowed Amount</p>
<p>A Referral is not required from Olin Health Center for maternity care, obstetric and gynecological treatment.</p>		

- c) Home Visits** - provided by a physician in the home or temporary residence. For additional information, refer to Home Health Care Services section.

Home Visits Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Home Visits are not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Unlimited visits		

- d) Inpatient Professional Services** - Physician Services provided while the Member is in an Inpatient hospital or Skilled Nursing Facility or Inpatient Rehabilitation center and billed by a physician

Inpatient Professional Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Inpatient Services are not provided by Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

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

Allergy Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Allergy testing and therapy are not provided at Olin Health Center. Allergy injections covered in full. Office visit Copay may apply.	Covered – 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

- f) Chiropractic Services and Osteopathic Manipulative Therapy** - when provided by a Participating Chiropractor or Osteopathic Physician and referred by your Primary Care Physician and Preauthorized by BCN

**Coverage**

Office visits are covered the same as Referral Physician office visits as defined above.

When an office visit and spinal manipulation are billed on the same day by the same provider, only one Copayment will be required for the office visit.

- Mechanical traction once per day is covered when it is performed with chiropractic spinal manipulation.
- Radiological Services and X-rays are covered when Preauthorized.

See Outpatient Services section and any attached Amendments for Cost Sharing information.

**Benefit Maximum**

Osteopathic manipulative therapies on any location of the body and chiropractic spinal manipulations to treat misaligned or displaced vertebrae of the spine are limited to the Benefit Maximum of 30 combined visits per Member per plan year. For example, a spinal manipulation performed by a Chiropractor will reduce the number of spinal manipulations available from an Osteopathic Physician.

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

Chiropractic Treatment Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Services are not provided at Olin Health Center - refer to BCN Network or Out-of-Network Benefits	Covered - \$15 Copay after Deductible then 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
<p><b>Note:</b> Benefits are limited to a maximum of 30 osteopathic and chiropractic visits per Member per plan year combined. Additionally, Olin Health Center, BCN Network and Out-of-Network visits are combined. For example, use of a visit in Olin Health Center will reduce the number of visits available in BCN Network and Out-of-Network.</p>		

**8.5 Continuity of Care for Professional and Facility Services**

*Continuity of Care for Existing Members*

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

**Physician and Facility Requirements**

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

- Notifies BCN of their agreement to accept the Approved Amount as payment in full for the services provided;

- Continues to meet BCN's quality standards; and
- Agrees to adhere to BCN medical and quality management policies and procedures.

### Medical Conditions and Coverage Time Limits

#### **Pregnancy Related**

If you are in your second or third trimester of pregnancy at the time of the treating physician's disaffiliation, services provided by your physician may continue through post-partum care (typically six weeks) for Covered Services directly related to your pregnancy.

#### **Life-threatening condition**

If you have a life-threatening disease or condition for which death is likely if the course of treatment is interrupted. Coverage for services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first.

#### **Serious and Complex Medical Conditions**

For Chronic (on-going), terminal illness and Acute medical conditions ( a disease or condition requiring complex on-going care such as chemotherapy, radiation therapy, surgical follow-up visits) when a course of treatment began prior to the treating provider's disaffiliation, Coverage for services provided by the disaffiliated provider may continue through the current period of active treatment or 90 calendar days from the time the provider's contract with BCN ended, whichever comes first. Your Participating Primary Care Physician must coordinate all other services in order for them to be Covered Services.

#### Coverage

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

**If the above conditions are not met, Covered Services will be paid at the Out-of-Network Benefit level.**

#### *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. In order for the services to be paid by BCN at the BCN Network Benefit level, at the time of enrollment you must have selected a Primary Care Physician who will coordinate your care with the Non-Participating Provider. You may participate in the Continuity of Care program only for the following conditions and only for the time periods described below:

## Coverage Time Limits and Qualification Criteria

### **Pregnancy Related**

If you are in your second or third trimester of pregnancy at the time of enrollment, coverage provided by your Non-Participating Provider may continue through post-partum care for Covered Services directly related to your pregnancy.

### **Terminal Illness**

If you were diagnosed as terminally ill (with a life expectancy of six months or less) and were receiving treatment from the Non-Participating Provider related to your illness prior to enrollment, Coverage for services provided by your Non-Participating Provider may continue for the ongoing course of treatment through death.

### **Serious and Complex Medical Conditions**

For Chronic and Acute medical conditions when a course of treatment began prior to enrollment, Coverage for services provided by the Non-Participating Provider may continue through the current period of active treatment or 90 calendar days from the time of enrollment, whichever comes first.

## Coverage

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

If the above conditions are not met, Covered Services will be paid at the Out-of-Network Benefit level.

## **8.6 Preventive and Early Detection Services**

We cover Preventive and Early Detection Services as defined in the federal PPACA. Preventive Services are modified by the federal government from time to time.

These Services must be provided or coordinated by your Primary Care Physician (SHS at Olin Health Center). Some Preventive Services are not performed at Olin Health Center but are provided in the BCN Network with no Cost Sharing. Cost Sharing does apply to Services received Out-of-Network.

Review the charts below before seeking Preventive Services.

### ***a) Health assessments, health screenings and adult physical examinations at intervals set in relation to your age, sex and medical history***

Health screenings include but are not limited to:

- Obesity
- Vision, glaucoma and hearing (See Section 9 for exclusions and limitations)
- EKG



- Type 2 diabetes mellitus
- Abdominal aortic aneurysm (one-time ultrasonography screening for smokers)

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

**b) Women’s health and well-being**

- Gynecological (well-woman) examinations including routine pap smear (lab service only)
- Mammography screening\*
- Screening for sexually transmitted diseases; HIV counseling and screening;
- Contraceptive counseling and methods; office administered contraceptive devices and appliances such as intrauterine devices (IUDs); implantable and injected drugs such as Depo-Provera; and diaphragms including measurement, fittings, removal, administration; and management of side effects
- Maternity counseling for the promotion and support of breast-feeding and prenatal vitamin counseling\*
- Routine prenatal office visits\*
- Breast pump and associated supplies needed to support breast-feeding covered only when authorized and obtained from a participating Durable Medical Equipment provider and when mandated by law (Refer to DME section for limitations and exclusions)\*
- Maternity screening for iron deficiency anemia, Hepatitis B Virus infection (at first prenatal visit) and Rh(D) incompatibility screening\*
- Screening for gestational diabetes\*
- Bone density screening\*
- Genetic counseling and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes\*
- Female sterilization Services\*
- Screening and counseling for interpersonal and domestic violence
- Genetic counseling and BRCA testing if appropriate for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes\*

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% *Some Service may not be available at SHS at Olin Health Center. Check with Olin Health Center before receiving a Service. <ul style="list-style-type: none"> <li>• A Referral is not required for mammograms.</li> <li>• You are encouraged to seek preventive Services in the BCN Network.</li> </ul>	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

**c) Immunizations** (pediatric and adult) as recommended by the Advisory Committee on Immunization Practices or other organizations recognized by BCN.

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Flu shots are covered in full in Olin Health Center and BCN Network. Travel immunizations are not available at SHS at Olin Health Center. NOTE: Not all immunizations are mandated by PPACA. To see a list of the preventive immunizations that are covered by PPACA, go to <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>		

**d) Newborn and well-child assessments and examinations**

SHS at Olin Health Center	BCN Network	Out-of-Network
Pediatric Services are not available at SHS at Olin Health Center	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

**e) Nutritional counseling** including Diabetes Self-Management and diet behavioral counseling

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

Other nutritional counseling Services may be covered when Preauthorized by BCN.

**NOTE:** Certain health education and health counseling Services may be arranged through your Participating Provider, but are not payable under your Coverage. Examples include but are not limited to:

- Lactation classes not provided by your physician
- Tobacco cessation programs (other than a BCN tobacco cessation program)
- Exercise classes

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

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% Some Services may not be available at Olin Health Center. Check with Olin Health Center for a specific Service.  You are encouraged to seek Preventive Services in the BCN Network	Covered – 100%	Covered - 80% after Deductible  20% Coinsurance of the Allowed Amount

**g) Depression Substance Use Disorder/chemical dependency screening**

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible  20% Coinsurance of the Allowed Amount

**h) Aspirin therapy** counseling for the prevention of cardiovascular disease

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible  20% Coinsurance of the Allowed Amount

**i) Tobacco use** and tobacco caused disease counseling

SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100%	Covered – 100%	Covered - 80% after Deductible  20% Coinsurance of the Allowed Amount

**NOTE:** If this Certificate of Coverage is amended by Deductible, Copayment and/or Coinsurance (“Cost Sharing”) Amendments, the attached Amendments will take precedence over the Certificate of Coverage for non-preventive services.

Cost Sharing will apply to non-routine diagnostic procedures. Any Member Cost Sharing for office visits will still apply with the following restrictions:

- If a recommended Preventive or Early Detection Service is billed separately from the office visit, then you will be responsible for the office visit Cost Sharing, but there will be no Cost Sharing for the Preventive or Early Detection Service.
- If a recommended Preventive or Early Detection Service is not billed separately from the Office Visit and the primary purpose of the office visit is the delivery of the Preventive or Early Detection Service, you will have no Cost Sharing for the office visit.
- If a recommended Preventive or Early Detection Service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of the Preventive or Early Detection Service, you will be responsible for payment of any Cost Sharing for the office visit.

**Note:** 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.

## **8.7 Inpatient Hospital (Facility) Services**

The following Inpatient Hospital (Facility) Services are covered when they are Medically Necessary and Preauthorized by BCN. Benefits for Physician Services are described under Professional Physician Services section. Services include but are not limited to the following:

- 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; and
- Maternity care and all related services when provided by the attending physician or Certified Nurse Midwife. The Certified Nurse Midwife must be overseen by a OB/GYN.

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

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

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

- 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.

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

Inpatient Hospital Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered – 95% after Deductible 5% Coinsurance  • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the allowed amount  • Preauthorization required

See section 8.3 Professional Physician Services section for Inpatient Professional Cost Sharing.

## 8.8 Outpatient Services

Outpatient Services are covered when they are Medically Necessary and Preauthorized by BCN.

You receive Outpatient Services in a variety of settings:

- Outpatient hospital setting
- Physician office
- Freestanding ambulatory Facility
- Dialysis center

Outpatient Services include but are not limited to:

- Facility and professional (physician) Services
- Surgical treatment
- Anesthesia
- Laboratory and pathology Services
- Radiology
- Chemotherapy, inhalation therapy, radiation therapy and dialysis
- Physical, speech and occupational therapy – See Outpatient Therapy Services section

- Injections (for allergy) - see Medical Professional Physician Services
- **Professional Services** - see Medical Professional Physician Services
- Durable medical equipment and supplies - see Durable Medical Equipment
- Diabetic supplies and equipment - see Diabetic Supplies and Equipment
- Prosthetic and orthotic equipment and supplies - see Prosthetic and Orthotics
- Diagnostic testing for learning disabilities
- Other Medically Necessary Outpatient Services and supplies

Outpatient Services Cost Sharing Facility and Professional Services		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – 100% Some Services are not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
<b>Note:</b> Outpatient diagnostic laboratory and pathology tests are covered in full.		

High Technology Outpatient Services Cost Sharing Such as CAT, MRI and PET scans Facility and Professional Services		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

NOTE: Lab and pathology Services are covered in full.

## 8.9 Emergency and Urgent Care Definitions

**Accidental Injury** - a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health. Broken bones and cuts, allergic reactions, frostbite, sunstroke, swallowing poison, overdose of medication and inhalation of smoke, carbon monoxide or fumes are considered accidental injuries.

**Emergency Services** - Services to treat Medical Emergency conditions as described below.

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

case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Routine care for minor medical problems such as headaches, colds, slight fever, back pain or follow-up care is not considered a medical emergency. A “Medical Emergency” is not a condition caused by an “accidental injury”.

**Stabilization** - the point at which there is reasonable probability that no material deterioration of a condition is likely to result from or occur during your transfer.

**Urgent Care Services** – Services that appear to be required in order to prevent serious deterioration to your health resulting from an unexpected illness or injury that could be expected to worsen if not treated within 24 hours. Examples include flu, strep throat, or other infections, foreign material in the eye, sprain or pain following a fall and a cut, sore or burn that does not heal.

### Coverage

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

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

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

Emergency Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - \$50 Copay then 5% Coinsurance thereafter	Covered - \$50 Copay then 5% Coinsurance thereafter

Urgent Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - 95% after Deductible 5% Coinsurance	Covered – 80% after Deductible 20% Coinsurance

**NOTE:** The Emergency Copayment may be waived for a Medical Emergency or Accidental Injury based upon presenting signs and symptoms as defined by BCN.

If you are admitted as an Inpatient because of a Medical Emergency or Accidental Injury, the Emergency Copay is waived. Instead, you will be responsible for the Inpatient Hospital Benefit as defined in Section 8.6.

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

Observation are subject to the Emergency Services Copayment guidelines above.

**Follow-up care in an Emergency Care Center or Urgent Care Center**, such as removal of stitches and dressings, is covered. If within 45 miles of Olin Health Center, you must return to Olin Health Center for follow-up care, even if the Emergency Room Physician refers you to someone else.

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

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

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

You are covered when traveling within or outside of the BCN Service Area for Emergency Services and Urgent Care Services that meet the conditions described above. (See Section 7.13 for additional information regarding out-of-area Coverage.

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.

## **8.10 Ambulance**

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

For ground ambulance, a covered destination may include:

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

For air ambulance, a covered destination may include:

- A hospital
- Another facility when Preauthorized by BCN

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

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



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

- The service must be Medically Necessary. Any other means of transport would endanger the Member’s health or life
- Coverage only includes the transportation of the Member’s 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 included 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 only when those Services are recommended by your treating physician and Preauthorized by BCN.

Air ambulance

Air Ambulance services must also meet these requirements:

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

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

Ambulance Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center	Covered - 95% 5% Coinsurance	Covered - 95% 5% Coinsurance

**Exclusions include but are not limited to**

- Transportation 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.

## 8.11 Reproductive Care and Family Planning Services

This Benefit includes:

- Infertility
- Sterilization
- Termination of Pregnancy
- Genetic Testing

### a) Infertility

#### *Basic Infertility*

Coverage includes diagnosis, counseling, select drugs and surgical treatment of Infertility when Medically Necessary and Preauthorized by BCN except as stated below and in Section 9. Following the initial sequence of diagnostic work-up, additional work-ups may begin only when BCN determines they are in accordance with generally accepted medical practice.

#### *Comprehensive Infertility*

- Ovulation induction with menotropins is subject to the Benefit Maximum of 6 cycles per lifetime.
- Intrauterine insemination is subject to the maximum Benefit of 6 cycles per lifetime.

Infertility Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefit	Covered - 95% after Deductible 5% Coinsurance • Preauthorization required	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
<b>Note:</b> Infertility Services are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

**Exclusions include but are not limited to**

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

**b) Sterilization**

Coverage includes Inpatient; Outpatient and office based adult sterilization Services.

**Female sterilization** - Covered in full as defined in the federal Patient Protection and Affordable Care Act for Women Preventive Services.

Female Sterilization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered – 100%	Covered - 80% after Deductible; 20% Coinsurance of the Allowed Amount

Male Sterilization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

**Exclusion includes but is not limited to**

Reversal of surgical sterilization for males and females

**c) Termination of Pregnancy**

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

Termination of Pregnancy Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Note: Benefit is limited to \$250 per Plan Year		

**d) Genetic Testing**

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

Genetic Testing Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

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

**Exclusion includes but is not limited to**

Genetic testing and counseling for non-members

**8.12 Skilled Nursing Facility Services**

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

Skilled Nursing Facility Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Unlimited days		

**Exclusions include but are not limited to**

- Bed-hold charges incurred when you are on an overnight or weekend pass during an Inpatient stay
- Custodial Care (See Section 9)

**8.13 Home Health Care Services**

Home Health Care Services for Members who are confined to their home as an alternative to long-term Hospital care. Home Health Care must be:

- Medically Necessary
- Provided by a Home Health Care agency
- Provided by professionals employed by the agency and who participate with the agency

We cover the following Services:

- Skilled Nursing Care provided by or supervised by a registered nurse employed by the home health care agency
- Intermittent physical, speech or occupational therapy  
 Note: Outpatient therapy limits defined in the Outpatient Therapy Services section do not apply.
- Other health care Services approved by BCN when they are performed in the Member’s home

Home Health Care Services Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Unlimited visits		

**Exclusions include but are not limited to**

- Housekeeping services
- Custodial Care (See Section 9)

**8.14 Hospice Care**

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

Hospice Care in a licensed hospice Facility, Hospital or Skilled Nursing Facility is covered. We

also cover Hospice Care in the home. Hospice Care has to be Medically Necessary and Preauthorized by BCN.

We cover the following Services:

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

NOTE: 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 is required.

Hospice Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

**Exclusions include but are not limited to**

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

**8.15 Home Infusion Therapy Services**

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

**Food Supplements**

Supplemental feedings administered *via tube*.

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

Supplemental feedings administered *via an IV*:

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

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

Home Infusion Therapy Services Care Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount •

## 8.16 Behavioral Health Services (Mental Health & Substance Use Disorder)

### A. Mental Health Care

We cover evaluation, consultation and treatment necessary to determine a diagnosis and Treatment Plan for mental health conditions that are in accordance with generally accepted standards of practice. Non-emergency Mental Health services must be Preauthorized as Medically Necessary by BCN with the exception of routine outpatient psychiatry and psychotherapy services. (Mental Health Emergency Services are covered pursuant to Emergency and Urgent Care section.)

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.

**Residential Mental Health Treatment** is treatment that takes place in a licensed domiciliary Facility which has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 or available afterhours with response time of 60 minutes to the facility to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that will allow the individual to reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the Member’s usual living environment; and
- Not based on a preset number of days such as standardized program (i.e. “30-Day Treatment Program”), however, the benefit design will be the same as your medical Inpatient benefit when Preauthorized by BCN.

**Partial Hospitalization Mental Health** is a comprehensive Acute Care program that consists of a minimum of 4 hours per day, at least 3 days per week. Treatment may include, but is not limited to psychiatric evaluation, counseling, medical testing, diagnostic evaluations and other Services in a Treatment Plan. Partial Hospitalization Services are often provided in lieu of Inpatient psychiatric Hospitalization.

**Intensive Outpatient Mental Health** services are Acute Care Services provided on an Outpatient basis. They consist of a minimum of 3 hours per day, 2 days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and/or referral to other services in a treatment plan.

**Outpatient Mental Health Services** include individual, conjoint, family or group psychotherapy, 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 BCN Behavioral Health Management at the number shown 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 to get care.

Inpatient Mental Health/Residential Mental Health/Partial Hospitalization Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Not applicable	Service must be Preauthorized by BCN Behavioral Health Management.	

Outpatient Mental Health/Intensive Outpatient Mental Health Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
3 visits per lifetime are covered in full for enrolled students only when provided at Olin Health Center  Covered – \$15 Copay thereafter	Covered – \$15 Copay after Deductible, no matter the location including online visits	Covered 80% after Deductible 20% Coinsurance of the Allowed Amount
Service must be Preauthorized by BCN Behavioral Health Management.		

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

See Section 9 for Exclusions and Limitations.



## ***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 other Services in a Treatment Plan.

Non-emergency Substance Use Disorder treatments must be Preauthorized as Medically Necessary by BCN with the exception of routine outpatient psychiatry and psychotherapy services. (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 Services provided in a secure full day (24 hour) setting to a Member who is ambulatory and does not require medical Hospitalization. Residential Services may include counseling, Detox, medical testing, diagnostic and medication evaluation and other Services specified in a Treatment Plan. Residential Substance Use Disorder Treatment is sometimes referred to as Intermediate Care. Residential Substance Use Disorder is not considered inpatient acute medical/surgical care in a hospital.

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

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

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

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

**Intensive Outpatient Substance Use 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 is not necessarily limited to individual, group and family counseling, medical testing, diagnostic and medication evaluation and other services specified in a treatment plan.

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

### Coverage

We cover Substance Use Disorder Services including counseling, medical testing, diagnostic evaluation and Detox in a variety of settings.

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

Detox/Residential/Intermediate Care/Partial Hospitalization/Partial Domiciliary Substance Use Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
Services require Preauthorization by BCN Behavioral Health Management.		

Outpatient/Intensive Outpatient/Domiciliary Intensive Outpatient Substance Use Disorder Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered – \$15 Copay	Covered – \$15 Copay after Deductible, no matter the location	Covered – 80% after Deductible 20% Coinsurance of the Allowed Amount
Services require Preauthorization by BCN Behavioral Health Management.		

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

See Section 9 for Exclusions and Limitations.

### 8.17 Outpatient Therapy Services

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:

- Medical rehabilitation – including but not limited to cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Chiropractic and Osteopathic mechanical traction
- Speech therapy
- Cognitive therapy
- Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to BCN medical policies

We cover Short-term Outpatient Therapy Services when meeting the following criteria:

- Preauthorized by BCN as Medically Necessary
- Treatment is provided for recovery from surgery, disease or injury
- Provided in an Outpatient setting
- Services are not provided by any federal or state agency or any local political subdivision, including school districts
- Results in meaningful improvement in your ability to do important day to day activities within 90 days of starting treatment

Habilitative Services that help a person keep, learn or improve skills and functioning for daily living are covered when Preauthorized by BCN as Medically Necessary. Examples include but are not limited to:

- Therapy for a child who isn't walking or talking at the expected age
- Physical and occupational therapy, speech-language pathology and other Services for people with disabilities

Short term Rehabilitative Outpatient Physical, Speech, Cognitive and Occupational Therapies Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered - \$15 Copay per visit <ul style="list-style-type: none"> <li>• Physical therapy only is available at Olin Health Center</li> <li>• Speech therapy and occupational therapy are available in BCN Network and Out-of-Network</li> </ul>	Covered – \$15 Copay after Deductible; 5% Coinsurance thereafter	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

- ✓ Outpatient Cognitive, Physical and Occupational Therapy - Limited to a combined Benefit Maximum of 30 visits per condition per Plan Year with Habilitative PT/OT visits
- ✓ Outpatient Speech Therapy – limited to 30 visits per Plan Year combined with Habilitative Speech therapy visits

Habilitative Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Covered - \$15 Copay per visit Physical therapy only is available at Olin Health Center Speech therapy and occupational therapy are available in BCN Network and Out-of-Network	Covered – \$15 Copay after Deductible; 5% Coinsurance thereafter	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
<ul style="list-style-type: none"> <li>✓ Outpatient Physical and Occupational Therapy – limited to a combined Benefit Maximum of 30 visits per condition per Plan Year combined with Rehabilitative visits</li> <li>✓ Outpatient Speech Therapy – limited to 30 visits per Plan Year combined with Rehabilitative speech therapy visits</li> </ul>		

NOTE: The maximum number of Outpatient therapy visits received is combined. For example, use of a visit in the BCN Network will reduce the visits available Out-of-Network.

NOTE: For rehabilitative and habilitative visits, 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 same day it counts as two visits against your limit.

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

- Services that can be provided by any federal or state agency or local political subdivision, including school districts, when the Member is not liable for the costs in the absence of insurance
- Vocational Rehabilitation including work training, work related therapy, work hardening, work site evaluation and all return to work programs
- Treatment during school vacations for children who would otherwise be eligible to receive therapy through the school or a public agency
- Craniosacral therapy
- Prolotherapy
- Rehabilitation Services obtained from non-Health Professionals, including massage therapists
- Strength training and exercise programs;
- Sensory integration therapy

**Speech therapy exclusions include but are not limited to**

- Sensory, behavioral, cognitive or attention disorders
- Treatment of stuttering or stammering
- Swallowing therapy for deviant swallow or tongue thrust
- Vocal cord abuse resulting from life-style activities or employment activities such as, but not limited to, cheerleading, coaching, singing
- Summer speech program - treatment for children who would be eligible to receive speech therapy through school or a public agency

**8.18 Durable Medical Equipment (DME)**

Durable Medical Equipment (DME) must be:

- Medically Necessary
- Preauthorized by BCN
- Used primarily for medical purposes
- Intended for repeated use
- Be useful primarily because of illness, injury or congenital defect.
- Prescribed by Olin Health Center or your treating physician

**Coverage**

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

DME is not available Out-of-Network. Items must be obtained from a BCN DME Participating Provider.

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

<b>Durable Medical Equipment Cost Sharing</b> <b>Must be Preauthorized and obtained from a BCN DME Participating Provider</b>
Covered – 95% after Deductible; 5% Coinsurance
Applies to Out-of-Pocket Maximum
For specific Coverage information and to locate a BCN DME Participating Provider, please call the number provided on the back of your BCN ID card. NOTE: Limited DME supplies are available at SHS at Olin Health Center when Preauthorized.

NOTE: Breast pump needed to support breast-feeding as required by law is covered in full when Preauthorized and obtained from a DME Participating Provider (See Preventive and Early Diagnosis section.)

*Limitations include but are not limited to:*

- The equipment must be considered DME under your Coverage and appropriate for home use.
- Medically Necessary
- Preauthorized by BCN
- Obtained from a BCN Network Participating Provider (Limited supplies are available at SHS at Olin Health Center)
- Prescribed by Olin Health Center or a treating physician
- The equipment is the property of the DME provider. When it is no longer Medically Necessary, you may be required to return it
- Repair or replacement, fitting and adjusting of DME only when needed as determined by BCN resulting from body growth, body change or normal use
- Repair of the item if it does not exceed the cost of replacement

*Exclusions include but are not limited to:*

- Deluxe equipment (such as motor-driven wheelchairs and beds, etc.) unless Medically Necessary for the Member or required so the Member can operate the equipment. (NOTE: If the deluxe item is requested when not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at the Member's option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that may be prescribed.)
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bed boards, bathtub lifts, overhead tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds)
- Physician's equipment (such as blood pressure cuffs and stethoscopes)
- Disposable supplies (such as sheets, bags, ear plugs, elastic stockings);
- Over the counter supplies including wound care (such as disposable dressing and wound care supplies) in absence of skilled nursing visits in the home
- 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, ramps, special telephone or communication devices)
- Equipment that is experimental or for research (See Section 9)
- Needles and syringes for purposes other than for treatment of diabetes
- Repair or replacement due to loss, theft, 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

### **8.19 Diabetic Supplies and Equipment**

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

Diabetic Supplies and Equipment must meet the criteria listed below:

- Determined to be Medically Necessary
- Preauthorized by BCN
- Prescribed by your Olin Health Center or treating physician
- Obtained from a BCN Participating Provider

We cover the following:

- Blood glucose monitors
- Test strips for glucose monitors, lancets and spring powered lancet devices, visual reading and urine testing strips
- Syringes and needles
- Insulin pumps and medical supplies required for the use of an insulin pump
- Diabetic shoes and inserts

Diabetic Supplies and Equipment are limited to basic equipment. Special features must be Medically Necessary and Preauthorized by BCN. Replacement of Diabetic Equipment is covered only when Medically Necessary.

Repair and replacement are covered only when needed as determined by BCN as not resulting from misuse. Repair of the item is covered if it does not exceed the cost of replacement.

<b>Diabetic Supplies and Equipment Cost Sharing</b> <b>Must be Preauthorized and obtained from a BCN Participating Provider</b>
Covered – 95% after Deductible; 5% Coinsurance Applies to Out-of-Pocket Maximum
For specific Coverage information and to locate a BCN Participating provider, please call the number provided on the back of your BCN ID card. NOTE: Limited supplies are available at SHS at Olin Health Center when Preauthorized.

NOTE: If you have prescription drug coverage through BCN, you may also obtain certain diabetic supplies and equipment through a BCN Participating Pharmacy as defined on your Drug List. Applicable prescription drug Cost Sharing will apply.

*Exclusions include but are not limited to:*

- Replacement due to loss, theft or damage, or damage that can be repaired.
- Deluxe equipment unless Medically Necessary for the Member. If the deluxe item requested is not Medically Necessary, the Approved Amount for the basic item may be applied toward the price of the deluxe item at your option. You are responsible for any costs over the Approved Amount designated by BCN for a deluxe item that may be prescribed.
- Alcohol and gauze pads

## **8.20 Orthotics and Prosthetics**

### **Definitions**

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

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

Prosthetic Devices can be either:

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

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

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

### **Coverage**

Coverage includes but is not limited to the following:

- Implantable or non-implantable breast Prostheses required following a Medically Necessary mastectomy
- Repair, replacement, fitting and adjustments 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)
- Scalp hair prosthesis as a result of hair loss due to injury, sickness or treatment of sickness



<b>Orthotics and Prosthetics Cost Sharing Must be Preauthorized and obtained from a BCN Participating Provider</b>
Covered – 95% after Deductible; 5% Coinsurance Applies to Out-of-Pocket Maximum
For specific Coverage information and to locate a BCN Participating provider, please call the number provided on the back of your BCN ID card. Limited devices are available at SHS at Olin Health Center when Preauthorized.
NOTE: Hair prosthesis (wig or hairpiece) for hair loss due to injury, sickness or the treatment of sickness are covered in full.

### **Internal Implantable Prosthetic Devices**

- ✓ Your Inpatient, Outpatient or office visit Benefit applies.
- ✓ Applies to the Out-of-Pocket Maximum

### **Limitations**

- The item must meet the Coverage definition of a Prosthetic or Orthotic Device
- Preauthorized by BCN
- Obtained from a BCN-approved supplier
- Olin Health Center or the treating physician 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 your option. You are responsible for any costs over the Approved Amount designated by BCN for the different type of item that may be prescribed
- Any special features that are considered Medically Necessary must be Preauthorized by BCN
- Replacement is limited to items that cannot be repaired or modified

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

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

- Sports-related braces
- Dental appliances, including bite splints
- Hearing aids; including bone anchored hearing devices
- Eyeglasses or contact lenses (except after lens surgery as listed above)
- Non-rigid appliances and over-the-counter supplies such as corsets, corrective shoes, Over the counter arch supports, foot orthotics
- Shoe inserts that are not attached to leg brace
- Over the counter supplies and disposable supplies such as compression stocking
- Devices that are experimental and research in nature

- Items for the convenience of the Member or care giver
- Repair or replacement due to loss, theft, damage or damage that cannot be repaired
- Duplicate appliances and devices

### **8.21 Organ and Tissue Transplants**

We cover organ or body tissue transplant and all related Services when the following conditions are met.

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

#### **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 in this Certificate of Coverage) when Preauthorized if the recipient’s health plan does not cover BCN Member donor charges.

<b>Organ and Tissue Transplant Cost Sharing</b>	
<b>SHS at Olin Health Center</b>	<b>BCN Network and Out-of-Network</b>
Not available at Olin Health Center	Covered - 95% after Deductible 5% Coinsurance Must be performed at a BCN-approved transplant facility Applies toward BCN Network Out-of-Pocket Maximum

#### **Exclusion includes but are not limited to**

- Community wide searches for a donor

### **8.22 Reconstructive Surgery**

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

- Correction of a birth defect that affects function;
- Breast reconstructive surgery following a Medically Necessary mastectomy including treatment of cancer). This may include nipple reconstruction, surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment for physical complications resulting from the mastectomy, including lymphedema
- Reduction mammoplasty (breast reduction surgery) for females

- Male mastectomy for treatment of gynecomastia
- Repair of extensive scars or disfigurement resulting from any surgery that would be considered a Covered Health Service under this Certificate of Coverage, disease, accidental injury, burns and severe inflammation, including but not limited to the following procedures:
  - ✓ Blepharoplasty of upper lids
  - ✓ Panniculectomy
  - ✓ Rhinoplasty
  - ✓ Septorhinoplasty

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

Reconstructive Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

### 8.23 Oral Surgery

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

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw;
- Dental anesthesia for oral surgery in an outpatient setting when Medically Necessary and Preauthorized by BCN;
- Medically Necessary surgery for removing tumors and cysts within the mouth;

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

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

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

Oral Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Applicable Cost Share will apply based on site of care	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

**Exclusions include but are not limited to**

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

See Section 9 for additional exclusions.

**8.24 Temporomandibular Joint Syndrome (TMJ) Treatment**

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

**Coverage**

We cover medical services and treatment for TMJ when Medically Necessary and Preauthorized by BCN.

- Primary Care Physician and specialty office visits for medical evaluation and treatment.
- Occlusal splint
- X-rays of the temporomandibular joint including contrast studies
- Surgery to the temporomandibular joint including, but not limited to condylectomy, meniscectomy, arthrotomy and arthrocentesis

TMJ Treatment Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

**Exclusions include but are not limited to**

- Dental and orthodontic Services, treatment, prostheses and appliances for or related to TMJ treatment (Occlusal splints limited to one per lifetime - covered only when diagnosed with TMJ and medically necessary)
- Dental X-rays

**8.25 Orthognathic Surgery**

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

**Coverage**

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

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

Orthognathic Surgery Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

**Exclusion includes but is not limited to**

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

**8.26 Weight Reduction Procedures**

Weight reduction procedures for the surgical treatment of morbid obesity are covered when:

- The medical criteria and guidelines established by BCN for having the procedure are met.
- The procedure is Preauthorized by BCN as Medically Necessary.

Weight Reduction Procedures Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - 95% after Deductible 5% Coinsurance	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount
NOTE: Benefits are payable in accordance with the type of Service incurred and the place where the Service is provided. Refer to the appropriate section in this document. Your office visit Copay may apply.		

### **Benefit Maximum**

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

### **8.27 Prescription Drugs and Supplies**

Prescription drugs and supplies are covered only if a BCN Participating Provider certifies to BCN and BCN agrees that the Covered drug in questions is Medically Necessary for the Member, based on BCN's approved criteria. Those Covered drugs are not payable without Prior Authorization by BCN.

#### **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 U. S. Food and Drug Administration (“FDA”) must approve the drug for cancer treatment.

Coverage is provided for the drug, regardless of whether the cancer is the specific cancer the drug was approved by the FDA to treat, if all of the following conditions are met:

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

Cancer Drug Therapy		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered in full	Covered in full

Cost of Administration		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered in full	Covered in full

**Coordination of Benefits for cancer therapy drugs**

If you have BCN Prescription Drug Amendment, drugs for cancer therapy that are self-administered will be covered by your BCN Prescription Drug Amendment before Coverage under this Certificate of Coverage will apply.

**c) Injectable Drugs**

The following drugs are covered as medical Benefits.

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

We may require selected Specialty Drugs be obtained by your Provider through a Specialty Pharmacy. BCN will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting.

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

**Cost Sharing**

In-Network Benefits	Out-of-Network Benefits
5% Coinsurance of the Approved Amount after In-Network Deductible	20% Coinsurance of the Approved Amount after Out-of-Network Deductible
Applies toward In-Network Out-of-Pocket Maximum	Applies toward Out-of-Network Out-of-Pocket Maximum

**Exclusions for In-Network and Out-of-Network Benefits 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 not covered under your medical Benefit.

This includes self-administered drugs for certain diseases such as:

- Arthritis
- Hepatitis,
- Multiple sclerosis
- Certain other illnesses or injuries.

Self-administered drugs are covered only when you have a BCN Prescription Drug Rider.

#### **d) Outpatient Prescription Drugs**

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

### **8.28 Clinical Trial**

#### **Definition**

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

- A federally funded trial, as described in PPACA legislation;
- 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 PPACA legislation.

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

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

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



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

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

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

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

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

## Coverage

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

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

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

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

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

## **8.29 Autism Spectrum Disorders**

### **Definitions**

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

Approved Autism Evaluation Center (“AAEC”) is an academic or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the ASD. AAEC evaluation is necessary for ABA. The AAEC must be approved by BCN.

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

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

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

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

treatment.

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

### **Benefits**

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

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

Services for the treatment of ASD are covered as follows:

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

### **Coverage**

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

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

ABA for Line Therapy Services is subject to the Cost Sharing as defined below. You are required to pay any Copayment at the time the Service is rendered. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Behavioral Health Services included in the Treatment Plan are subject to the BCN Network office

visit Copay or Out-of-Network Cost Sharing as defined in Section 8.15 of this Certificate of Coverage. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

Outpatient Therapy Services included in the Treatment Plan are subject to the Cost Sharing as defined in Section 8.17 Outpatient Therapy Services. You are required to pay any Copay at the time of service. You are responsible for meeting the Deductible prior to BCN paying for Covered Services.

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

This Coverage overrides certain exclusions as defined in this Certificate of Coverage such as:

- Exclusion of treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities;
- Treatment solely to improve cognition concentration and attentiveness, organizational or problem-solving skills, academic skills, impulse control; and
- Other behaviors for which behavior modification is sought.

Applied Behavioral Analysis Cost Sharing		
SHS at Olin Health Center	BCN Network	Out-of-Network
Not provided at Olin Health Center – refer to BCN Network or Out-of-Network Benefits	Covered - \$15 Copay after Deductible	Covered - 80% after Deductible 20% Coinsurance of the Allowed Amount

### Benefit Limitations

Coverage is available subject to the following requirements:

- **Preauthorization** - Services performed under the recommended Treatment Plan must be approved for payment during BCN’s Preauthorization Process. If Preauthorization is not obtained, rendered Services will not be covered and the Member may be held responsible for payment for those Services.
- **Prior Notification** - BCN must receive prior notification of the evaluation and diagnostic assessment of the Member.
- **Providers** - All Services to treat ASD must be performed by a BCN approved provider.
- **Required Diagnosis for Applied Behavior Analysis** - The Member must be evaluated and diagnosed with ASD by a Participating psychiatrist, development pediatrician or other professional as agreed upon by the AAEC in order to receive Preauthorization for ABA. Other Preauthorization requirements may also apply. The requirement to be evaluated and diagnosed by the AAEC does not exist for other Services related to ASD.
- **Termination at age 19** - Benefits are limited to children up to and including the age of 18. This age limitation does not apply to Outpatient Mental Health Services (excluding ABA Services) and Services used to diagnose ASD. Benefits terminate on the child’s 19th birthday

- **Treatment Plan** – ABA Services must be included in a Treatment Plan recommended by a BCN AAEC that evaluated and diagnosed the Member’s condition.
  - Measurable improvement in the Member’s condition must be expected from the recommended Treatment Plan. Once treatment begins, the plan will be subject to periodic assessment by BCN nurse or case manager.

**Exclusions**

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

**8.30 Gender Dysphoria Treatment**

**Definitions**

**Gender Dysphoria**

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

**Gender Reassignment Services**

A collection of Services that are used to treat Gender Dysphoria

These services must be considered Medically Necessary and may include hormone treatment and gender reassignment surgery, as well as counseling and psychiatric Services.

**Coverage**

We cover Services for the treatment of Gender Dysphoria when determined to be Medically Necessary and Preauthorized by BCN. The Provider must supply documentation supporting that you meet the BCN medical criteria and established guidelines.

<b>Gender Dysphoria Treatment Cost Sharing</b>		
<b>SHS at Olin Health Center</b>	<b>BCN Network</b>	<b>Out-of-Network</b>
Some services are available at Olin. Cost Share applied dependent on the service provided.	Covered - 90% after Deductible 10% Coinsurance	Covered – 70% after Deductible 30% Coinsurance of the Allowed Amount
Your Inpatient and Outpatient Benefit Cost Sharing applies including office consultations as defined in this Certificate of Coverage.		

**Exclusions include but are not limited to**

- Experimental or investigational treatment
- Reversal of transgender surgical procedures
- Gender reassignment services that are considered cosmetic and not medically necessary such as:
  - Abdominoplasty

- Blepharoplasty
- Breast enhancements
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Chondrolaryngoplasty (Adams Apple reduction)
- Collagen injections
- Construction of clitoral hood
- Drugs for hair loss or growth
- Forehead lift
- Hair removal
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Speech-language therapy
- Non-covered services

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

## Section 9: Exclusions and Limitations

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

### 9.1 *Unauthorized Services*

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

Current information regarding Services that require Preauthorization is available by calling Customer Service at the number shown on the back of your BCN ID card.

### 9.2 *Services Received While a Member*

We will only pay for Covered Services you receive while you are a Member and covered under this Certificate and any 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.

A Service is considered to be received on the date on which Services or supplies are provided to you. We can collect from you all costs for Covered Services that you receive after your Coverage terminates, plus the cost of recovering those charges (including attorney's fees).

### 9.3 *Services That Are Not Medically Necessary*

Services that are not Medically Necessary are not covered unless specified in this Certificate.

The Medical Director makes the final determination of Medical Necessity based upon BCN internal medical policies.

### 9.4 *Non-Covered Services*

Coverage does not include the following Services:

- Services that do not meet the terms and guidelines of this Certificate of Coverage
- Office visits, exams, treatments, tests and reports for any of the following:
  - Employment
  - Licenses and marriage applications
  - Insurance
  - Travel (immunizations for purposes of travel or immigration are a Covered Health Benefits)
  - School purposes, camp registration, and sports physicals
  - Educational and behavioral evaluations performed at school
  - Legal proceedings such as parole, court and paternity requirements
  - Completion or copying of forms or medical records, medical photography, charges and interest on late payments, and charges for failure to keep scheduled appointments
- 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)

- Expenses of travel, transportation or lodging, except for covered ambulance services
- Autopsies
- Employment related counseling
- Modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities
- Fees incurred for collections, processing and storage of blood, cells, tissues, organs or other bodily parts in a family, private or public cord bank or other facility without immediate medical indication
- Testing to determine parentage or DNA testing
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself
- Services performed by a provider with your same legal residence
- Charges in excess of the Approved Amount
- Private duty nursing
- Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care
- Services outside the scope of the practice of the servicing provider
- All facility, ancillary and physician services, including diagnostic tests, related to experimental or investigational procedures
- Expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
- Psychoanalysis and psychotherapy that is not intended or likely to produce meaningful improvement.
- 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. These centers and programs are not considered residential treatment facilities.
- 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 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
- Services to hold or confine a person under chemical influence when no medical services are required
- The costs of a private room or apartment
- Non-medical services including enrichment programs like
  - Dance therapy
  - Art therapy
  - Equine therapy
  - Ropes courses
  - Music therapy
  - Yoga and other movement therapies
  - Guided imagery
  - Consciousness raising
  - Socialization therapy
  - Social outings and education/preparatory courses or classes

### **9.5 Cosmetic Treatment and Procedures**

Cosmetic treatment and procedures are performed primarily to improve appearance and/or self-esteem. It does not correct or materially improve a physiological function.

We do not cover cosmetic surgery including, but not limited to:

- Elective rhinoplasty
- Spider vein repair
- Breast augmentation
- Treatment of acne
- Any related Services, such as pre-or post-surgical care, follow-up care or reversal or revision of the surgery

### **9.6 Prescription Drugs**

There is no Coverage for the following drugs.

- Outpatient prescription drugs
- Over-the-counter drugs
- Products or any medicines incidental to Outpatient care except as defined in Section 8

However, a prescription drug Rider may be issued to you that allows Coverage.

### **9.7 Military Care**

Care for diseases or disabilities connected with military service are not covered if you are legally entitled to obtain services from a military Facility, and such a Facility is available within a

reasonable distance.

### **9.8 Custodial Care**

Custodial Care is used for maintaining the basic need for food, shelter, housekeeping services, clothing and help with activities of daily living.

We do not pay 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 of half-way house placement or any other setting that is not required to support medical and Skilled Nursing Care.

### **9.9 Comfort and Convenience Items**

Coverage does not include the following even when the items are prescribed by a Physician.

- Personal comfort
- Convenience items
- Telephone
- Television or similar items  
(See also Durable Medical Equipment section for exclusions)

### **9.10 Court Related Services**

- There is no coverage for court ordered services including but not limited to pretrial and court testimony, a court-ordered exam or the preparation of court-related reports that do not meet Coverage requirements.
- There is no coverage for court-ordered treatment for Substance Use Disorder or mental illness except as specified in Sections 8.
- There is no coverage for services related to your commission of a crime or participation in an illegal activity.
- There is no coverage for services rendered while you are in the custody of law enforcement.

### **9.11 Elective Procedures**

The following Elective Procedures are not covered.

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

## **9.12 Dental Services**

The following dental Services are not covered.

- Routine dental Services and procedures
- Diagnose or treat of dental disease
- Extraction of wisdom teeth
- Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures
- Restoration or replacement of teeth
- Orthodontic care
- X-rays or anesthesia administered in the dental office for dental procedures even if related to a medical condition or treatment, except as specifically stated in Section 8;
- Initial evaluation and services when obtained later than 72 hours after the injury or traumatic occurrence
- Prosthetic replacement of teeth that had been avulsed or extracted as a result of a trauma
- Repair of damage to fixed or removable bridges, dentures, veneers, bondings, laminates or any other appliance or prosthesis placed in the mouth or on or about the teeth.

## **9.13 Services Covered Through Other Programs**

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

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

## **9.14 Alternate Services**

Alternative Services are not covered. Alternative treatments are not used in standard Western medicine. It is not widely taught in medical schools. Services include but are not limited to:

- Acupuncture
- Hypnosis

- Biofeedback
- Herbal treatments
- Massage therapy
- Therapeutic touch
- Aromatherapy
- Light therapy
- Naturopathic medicine (herbs and plants)
- Homeopathy
- Yoga
- Traditional Chinese medicine

Evaluations and office visits related to alternative services are not covered.

### **9.15 Vision Services**

The following Vision Services or items are not covered:

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

### **9.16 Hearing Services**

The following Hearing Services or items are not covered:

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



