

The contract between you, the member, and Blue Care Network (BCN) of Michigan includes this booklet, **General Provisions**, and the booklet, **Your Benefits**. BCN is an independent corporation operating under a license from the Blue Cross Blue Shield Association, which is an association of independent Blue Cross Blue Shield Plans. This Association permits BCN to use the Blue Cross Blue Shield Service Mark in Michigan.

When you enroll in BCN, you understand that:

- BCN is not contracting as the agent of the Association.
- You have not entered into the contract with BCN based on representations by any person other than BCN.
- No person, entity or organization other than BCN will be held accountable or liable to you for any of BCN's obligations created under the contract.
- There are no additional obligations on the part of BCN other than those obligations stated under the provisions of the contract with BCN.

Blue Care Network

General Provisions

Blue Care Network (BCN) is a Health Maintenance Organizations (HMO) licensed by the state of Michigan and affiliated with Blue Cross Blue Shield of Michigan. Your Certificate (*Your Benefits and General Provisions*) is issued by your BCN health plan and is an agreement between you as an enrolled member and BCN.

If your coverage is arranged through your employment, your eligibility and benefits will also be subject to the contract made between your employer and BCN.

Eligible members are entitled to the HMO services and benefits described in your Certificate in exchange for the premium paid to BCN.

By enrolling in this health plan and accepting this Certificate, you, the member, agree to abide by the rules as stated in this Certificate. You also recognize that, except for emergency health services, only those health care services provided by your Primary Care Physician or arranged or approved by BCN are a benefit under this Certificate.

Definitions

These definitions will help you understand the terms used in this booklet.

BCN is Blue Care Network, the Health Maintenance Organization in which you are enrolled.

Certificate is the two booklets we issue to you that describe your coverage, and any riders we issue that change your coverage:

- **Your Benefits** is a detailed description of your health care coverage, including exclusions and limitations.
- **General Provisions** (this booklet) describes the rules of your BCN health coverage plan.

Enrollment means submitting a completed enrollment form and paying the necessary premium to BCN.

Family Dependent is an eligible family member who is enrolled for health care coverage with BCN. A dependent must meet the requirements stated in Part 1, Section 1.3.

Geographic Region is the counties covered by your BCN regional office.

Group is the legal entity that contracted with BCN on behalf of its employees to receive the benefits described in the Certificate.

Hospital is a state-licensed, acute-care facility that provides continuous, 24-hour inpatient medical, surgical or obstetrical care. It is not primarily a nursing care facility, rest home, home for the aged or a facility to treat substance abuse, psychiatric disorders or pulmonary tuberculosis.

Member is the subscriber or an eligible dependent entitled to benefits under this Certificate.

Non-Group Subscriber is one who enrolls for BCN coverage and pays the premiums for coverage directly rather than through a group.

Open Enrollment Period is a period of time each year when eligible people may enroll or disenroll in BCN.

Primary Care Physician is a licensed medical doctor (MD) or doctor of osteopathy (DO) affiliated with BCN as a Primary Care Physician and located in your geographic region.

Premium is the amount prepaid monthly for coverage. For group coverage, this amount may include employee contributions.

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

Service Area is the geographic area through approval by state authorities that is served by BCN.

Skilled Nursing Facility is a state-licensed, certified nursing home that is affiliated with BCN and that provides a high level of specialized care to members. It is an alternative to extended hospital stays.

Subscriber is the eligible person who has enrolled for health care coverage with BCN. This person is the one responsible for payment of health care coverage premiums or whose employment is the basis for coverage eligibility. This person is also known as a “member.”

Other **members** are those dependents of the subscriber who are eligible for coverage.

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Part 1: Eligibility, Enrollment and Effective Date of Coverage

This section describes eligibility, enrollment and effective date of coverage for the five types of subscribers listed below.

All BCN subscribers and members must meet eligibility requirements established by BCN. Certain requirements depend on whether the subscriber is:

- a group subscriber
- a non-group subscriber / group-conversion subscriber
- family dependent
- dependent under a qualified medical child support order
- principally supported child

All members must live in the BCN service area to be eligible for coverage unless stated otherwise in this booklet.

1.1 Group Subscriber

Eligibility

A group subscriber must do **all** of the following:

- live in the BCN service area at least nine months out of the year;
- be an active employee or eligible retiree of a group; and
- meet the group's eligibility requirements.

Enrollment

A new employee must enroll within 30 days of becoming eligible or during an open enrollment period.

NOTE: If the employee declines enrollment because of having other coverage, and that coverage ends, he/she may enroll if:

- Any COBRA coverage is exhausted, and
- The other coverage was terminated as a result of loss of employer contributions or loss of eligibility.

The employee must request enrollment within 30 days after the other coverage ends.

Effective Date

The effective date of coverage depends on the agreement between the group and BCN.

1.2 Non-Group Subscriber

Eligibility

A non-group subscriber must:

- live in the BCN service area at least nine months out of the year;
- not be eligible for enrolling in group coverage or group conversion coverage;
- not be eligible for or enrolled in other health care coverage as a subscriber or dependent, including Medicare.

Enrollment

Enrollment takes place during an open enrollment period or when the member is converting from group coverage to non-group coverage. See Part 6.

Effective Date

The effective date of coverage is the date designated by BCN.

1.3 Family Dependent

Eligibility

A family dependent may be either:

- the legally married **spouse** of the subscriber or
- a **dependent** of the subscriber – an unmarried child of the subscriber or of the subscriber's spouse by birth, legal adoption, or legal guardianship

NOTE: Children of the subscriber's spouse must live with the subscriber at least 50% of the time.

Dependent children are eligible until they become 19 years old. The dependent's enrollment terminates at the end of the calendar year in which he or she becomes 19 years old.

Exception: An unmarried, dependent child who becomes 19 while enrolled in BCN and who is totally and permanently disabled may continue coverage if:

- The dependent is incapable of self-sustaining employment because of mental retardation or physical handicap;
- The dependent must rely primarily on the subscriber for financial support; and
- The dependent lives in the service area.

The subscriber must submit to BCN the proof of this disability and dependence within 30 days of the dependent's 19th birthday. BCN may require annual proof of continued disability and dependence.

NOTE: A dependent whose only disability is a learning disability or substance abuse does not qualify for coverage after age 19.

Enrollment

Any eligible dependents may be added to the subscriber's contract:

- during the annual open enrollment period
- when the subscriber enrolls
- within 30 days of a 'qualifying event,' that is, birth, marriage, placement for adoption, etc.

NOTE: Other non-enrolled eligible dependents may also be added at the same time as the newly qualified dependent.

If the subscriber's dependents were not enrolled because of other coverage, and they lose their coverage, the subscriber may add them within 30 days of their loss of coverage.

Effective Date of Coverage

- Coverage is effective on the date of the qualifying event, if the dependent is enrolled within 30 days of the event.
- If the dependent is not enrolled within 30 days, coverage will not begin until the next open enrollment period's effective date.
- For a dependent who lost coverage and notifies BCN within 30 days, coverage will be effective when the previous coverage lapses. If you do not notify BCN within 30 days, coverage will not begin until the next open enrollment period's effective date.
- Adopted children must be covered from the date of **placement**.

NOTE: Placement means when the subscriber becomes legally responsible for the child; therefore, the child's coverage may begin before the child lives in the subscriber's home.

1.4 Dependent under a Qualified Medical Child Support Order

Eligibility

The child must:

- be under 19 years old and unmarried; and
- be under court or administrative order that his or her medical care is the subscriber's legal responsibility.

NOTE: A copy of the court order, court-approved settlement agreement or divorce decree is required to enroll the child. If you have questions about whether an order is 'qualified' for purposes of ERISA, call your group representative or BCN.

Enrollment

- The child may be enrolled at any time, preferably within 30 days of the court order.

In addition:

- If the subscriber parent does not apply, the other parent **or** the state Medicaid agency may apply.
- The subscriber parent may change from individual coverage to family coverage.
- If the parent that is under court order to provide coverage for the child is not already a subscriber, that parent may enroll (if eligible) when the child is enrolled.
- Neither parent may disenroll the child from an active contract while the court order is in effect, unless the child becomes covered under another plan.

Effective Date of Coverage

- If BCN receives notice within 30 days of the court order, coverage is effective as of the date of the court order.
- If BCN receives notice after 30 days of the order, coverage is effective on the date BCN receives notice.

1.5 Principally Supported Child

Eligibility

A principally supported child must:

- be under 19 years of age and unmarried;
- live full-time in the home with the subscriber;
- not be eligible for Medicare, and
- be dependent on the subscriber for principal support in accordance with Internal Revenue Service standards, and have met these standards for at least six full months prior to applying for coverage.

Enrollment

You may apply for coverage for a principally supported child after you have been the principal support for six months; however, coverage does not begin for three more months.

To apply, you must furnish the following:

- evidence that the child was reported as a dependent on the subscriber's most recently filed tax return **or**
- evidence and a sworn statement that the child qualifies for dependent tax status in the current year.

To continue coverage, you must furnish proof of eligibility every year.

Effective Date of Coverage

Coverage for principally supported children begins on the first day of the month, 90 days after application and proof of support. The premium payment must have been received by BCN prior to the effective date of coverage.

1.6 Additional Eligibility Guidelines

The following guidelines apply to **all** members:

- **Medicare:** If a member becomes eligible to enroll in Medicare, the member is eligible to enroll in only the applicable BCN Medicare program **except** when Medicare is the secondary payer by law.
- **Service Area Waiver:** Under certain circumstances BCN may waive the service area requirement in writing for a subscriber and family dependents who live outside the service area.
- **Change of Status:** You agree to notify BCN within 30 days of any change in eligibility status of you or any family dependents. **When a member is no longer eligible for coverage, he or she is responsible for payment for any services or benefits.**
- **Members admitted to a hospital or skilled nursing facility** prior to the effective date of coverage will be covered for inpatient care on the effective date of the Certificate **only** if:
 - The member has no continuing coverage under any other health benefits contract, program or insurance.

Part 2: Other Party Liability

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

- Are not provided or pre-authorized by BCN and a Primary Care Physician, and
- Are not a benefit under this Certificate.

2.1 Nonduplication

- BCN provides each member with full health care services within the limits of this Certificate.
- BCN does not duplicate benefits or pay more for covered services than the actual fees.
- Coverage for your benefits will be reduced to the extent that the benefits are available or payable under any other certificate or policy covering the member, whether or not you make a claim for the benefits.

2.2 Auto Policy and Workers' Compensation Claims

- This Certificate is a coordinated certificate of coverage. That is, services and treatment for any automobile-related injury that are paid or payable under any automobile or no-fault automobile policy will not be paid by BCN. BCN will not allow "double-dipping" whereby you would recover payment for the same services from both BCN and the automobile or no-fault carrier.
- Services and treatment for any work-related injury that are paid or payable under any workers' compensation program will not be paid by BCN.
- If any such services are provided by BCN, BCN has the right to seek reimbursement from the other program or insurer.

2.3 Coordination of Benefits (COB)

NOTE: "Certificate" and "Policy" used here include a certificate, contract or policy issued by:

- a health or medical care corporation,
- a hospital service corporation,
- a health maintenance organization,
- a dental care corporation,
- an insurance company,
- a labor-management trustee plan,
- a union welfare plan,
- an employer organization plan, or
- an employer self-insurance plan

in connection with a group disability benefit plan under which health, dental, hospital, medical, surgical or sick care benefits are provided to subscribers.

"Determination of benefits" means determining the amount that will be paid for covered services.

“Coordination of Benefits” means determining which certificate or policy is responsible for paying benefits for covered services first (primary carrier) when a member has dual coverage. Then, benefits payments are coordinated between two carriers to provide 100% coverage whenever possible for services covered in whole or in part under either plan, but not to pay in excess of 100% of the total amounts to which providers or members are entitled.

Coordination

When a member has coverage under a certificate or policy that does not contain a coordination of benefits provision, that certificate or policy will pay first. This means benefits under the other coverage will be determined before the benefits of your BCN Certificate.

After those benefits are determined, BCN’s benefits and the benefits of the other plan will be coordinated to provide 100% coverage whenever possible for services covered partly or totally under either plan. In no case will payments be more than the amounts to which providers or members are entitled.

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

- Are not provided or pre-authorized by BCN and a Primary Care Physician, and
- Are not a benefit under this Certificate.

Order of Benefits Determination (which policy will pay first)

When a member has coverage under another policy or certificate that does have a coordination of benefits provision, these rules apply:

- 1) The benefits of the policy that covers the person as a **subscriber** (policy-holder) will be determined first. The benefits that cover the person as a **dependent** will be determined second.
- 2) If two policies cover a person as a dependent, the policy of the person whose birthday falls earlier in the calendar year will be considered primary, i.e., those benefits will be determined first.
- 3) If two policies cover a person as a dependent and the birthdays of the two policy-holders are identical, the policy that has covered the patient longer will be primary.

NOTE: If either policy or certificate is lawfully issued in another state, and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries, and each policy or certificate determines its payment of benefits after the other, the policy that does not have the COB procedure based on birthdays will determine who pays first.

- 4) If the claim is for a dependent minor child, payment of benefits will be determined as follows:
 - a) If the parents of the minor child are divorced, and the divorce decree or court order places financial responsibility for medical, dental or other health care expenses on one specific parent, the policy of that parent will be primary.
 - b) If the parents of the child are legally separated or divorced, and the parent with custody has not remarried and a court order does not specify which parent is responsible for medical coverage, the policy that covers the child as a dependent of the custodial parent will be paid first. (Also see paragraph a.)

- c) If the parents are divorced and the custodial parent has remarried:
 - The benefits of the custodial parent’s policy will be paid before the benefits of the custodial step-parent.
 - The policy that covers the minor child as a dependent of the custodial parent’s spouse will be paid before the benefits that cover the minor child as a dependent of the non-custodial parent.
- 5. If paragraphs 1, 2, 3 or 4 do not establish the order in which benefits should be paid, the policy or certificate that has covered the child longer will pay first, subject to the following:
 - a) The benefits of a policy of a person who is laid-off or retired will be secondary to any other policy covering the minor child.
 - b) If either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees, and each policy determines its benefits after the other, then paragraph a) does not apply.

COB Exception

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

COB Administration

- If BCN determines that benefits under this Certificate should have been reduced because of benefits available under another certificate or policy, BCN has the right to:
 - recover any payments made to the member directly from the member or
 - assess a reasonable charge for services provided by BCN in excess of BCN’s liability

If benefits that should have been paid by BCN have been provided under another certificate or policy, BCN may directly reimburse whoever provided the benefits payments.

- For COB purposes, BCN may release, claim or obtain any necessary information from any insurance company or other organization. Any member who claims benefits payment under this Certificate must furnish BCN with any necessary information or authorization to do this.

2.4 Subrogation

Subrogation means that BCN has the same right as a member to recover expenses for services for which another person or organization is legally liable, to the extent that BCN has provided or paid for the services. BCN will be subrogated to the member’s right of recovery against the liable party.

- a) When you accept a BCN ID card, you agree that, as a condition to receiving benefits and services under this Certificate, you will make every effort to recover funds from the liable party. If you recover any funds, you will reimburse BCN. BCN shall have a lien against any such recoveries of funds whether by judgment, settlement, compromise or reimbursement. This applies no matter how the recovered funds are designated, i.e., economic or non-economic damages.

- b) When you accept a BCN ID card, it is understood that you acknowledge BCN's right of subrogation. If BCN requests, you will authorize this action through a subrogation agreement. If a subrogation lawsuit by you or by BCN results in a financial recovery greater than the services and benefits provided by BCN, BCN has the right to recover its legal fees and costs out of the excess.
- c) You or your representative will do whatever is necessary to enable BCN to implement the provisions of this Section. If you hire a lawyer to pursue a claim, you must inform the lawyer of BCN's rights under this Certificate. When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and BCN, the costs and legal expenses will be divided equitably.
- d) You agree not to compromise or settle a claim or take any action that would prejudice the rights and interests of BCN without getting BCN's prior written consent.
- e) If you refuse or do not cooperate with BCN regarding subrogation, it will be grounds for terminating membership in BCN. BCN will have the right to recover from you the value of services and benefits provided to you.

Part 3: Member Rights and Responsibilities

3.1 Confidentiality of Health Care Records

A consent to release of medical information is written on your BCN identification card. By using your identification card and as a condition of receiving benefits under this Certificate you consent to the release of information from your medical records and information received from your health care providers incident to the doctor-patient relationship to BCN and to your Primary Care Physician.

Your health care records will be kept confidential by BCN and your Primary Care Physician. BCN will not disclose information from your medical records without your consent except in connection with the administration of this Certificate, when required by law, for use of nonidentifying data for statistical studies or in bona fide medical research or education.

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

3.2 Inspection of Medical Records

You have access to your own medical records or those of your minor children or wards at the Medical Office during regular office hours. However, 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

You may select a Primary Care Physician from the list of BCN physicians in your geographical area. BCN will make every attempt to honor your choice. A female Member may also directly access any affiliated obstetrician gynecologist for all obstetric and routine gynecologic care without a referral. The female Member retains the right to receive the obstetrical and/or gynecological services directly from her Primary Care Physician.

The parent or guardian of a BCN Member under the age of eighteen (18) years (referred to as a “Minor”) may select an affiliated pediatrician as the Minor’s Primary Care Physician. Alternatively, the parent or guardian of a Minor may select a BCN affiliated family practitioner or general practitioner as the Minor’s Primary Care Physician, and may access a BCN affiliated pediatrician for general pediatric services for the Minor (hereinafter “Pediatric Services”). No referral is required for a Minor to receive Pediatric Services from the affiliated pediatrician.

A Member wishing to change Primary Care Physicians may do so by making arrangements with BCN. If after reasonable efforts, the Member and Primary Care Physician are unable to establish and maintain a satisfactory physician-patient relationship, BCN may transfer the Member to another Primary Care Physician. If a satisfactory physician-patient relationship cannot be established and maintained, BCN may ask you to disenroll. In some cases, the contract may be terminated, which will affect all Members on the contract. See Section 5.3.

3.4 Refusal to Accept Treatment

You have the right to refuse treatment or procedures recommended by BCN physicians 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 BCN 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 regards as medically or professionally inappropriate, BCN is no longer financially or professionally responsible for treating the condition.

3.5 Complaint and Grievance Procedure

If you have a complaint or grievance regarding any aspect of BCN’s services, you must follow the procedure established by BCN. You receive a copy of this procedure when you become a member. You also may obtain a copy at any time by contacting BCN at 1-800-662-6667.

If grievances are not settled through BCN’s procedure, you may appeal to the

Office of Financial and Insurance Services
Division of Insurance, Health Plans Division
611 Ottawa, Second Floor
PO Box 30220
Lansing, MI 48909-7720

3.6 Member’s Role in Policy-Making

At least one third of the Board of Directors of BCN will consist of BCN members, elected by subscribers. BCN provides nomination and election procedures to subscribers each year.

3.7 PCP Notification of Termination

Each member may receive notification of termination from his or her physician with 15 days of knowledge of the termination effective date. The physician can continue care with a terminally ill member, diagnosed as such prior to the physician's notification of termination from the plan.

Limitations and Exclusions:

If the physician provides notification to the member, BCN will permit the member to continue an ongoing course of treatment as follows:

1. For 90 days from the date of notice to the member by the physician of the physician's termination.
2. Through post-partum care directly related to the pregnancy if the member is in her second or third trimester of pregnancy at the time of the physician's termination.
3. The member must have been diagnosed as terminally ill prior to receiving notification of physician's termination.

Continuation of care only applies if the physician adheres to BCN's policies and procedures.

Part 4: Forms, Identification Cards, Records and Claims

4.1 Forms and Applications

Applicants and BCN members must complete and submit any applications, medical questionnaires or other forms that BCN requests within reason. You warrant that any information you submit is true, correct and complete. If you intentionally submit false or misleading information to BCN or omit any requested information, it may be grounds for refusing an application or for terminating your enrollment.

4.2 Identification Card

BCN issues identification cards to members. You must present these cards whenever you receive or seek services from a provider. This card is the property of BCN. BCN may request that the card be returned at any time.

To be entitled to benefits, the person using the card must be the member for whom all premiums have been paid. If a person is not entitled to receive services, the person must pay for the services received.

If your card is lost or stolen, report it to BCN immediately.

4.3 Misuse of Identification Card

If any BCN member does any of the following:

- misuses the identification card,
- repeatedly fails to present the card when receiving services from a provider,

- permits any other person to use the card, and/or
- attempts to or defrauds BCN,

BCN may confiscate the card, and all rights of the member under this Certificate will terminate.

4.4 Membership Records

- BCN will keep membership records.
- BCN will not provide coverage unless information is submitted in a satisfactory format by a group or a member.
- Any incorrect information submitted to BCN may (and should) be corrected. However, you will be responsible for reimbursing BCN for any service paid by BCN based on incorrect information.

4.5 Authorization to Receive Information

By accepting coverage under this Certificate, you agree that:

- BCN may obtain any information from providers in connection with services to a member.
- BCN may disclose any of your medical information to your Primary Care Physician.
- BCN may copy records related to your care.

4.6 Member Reimbursement

There is no reason for you to pay a provider for covered services under this Certificate (other than copays), but if circumstances require that you do, and you can prove that you have, BCN will reimburse you for those covered services.

- You must provide written proof of the payment within 12 months of the date of service.
- Claims submitted more than 12 months after the date of service will not be paid.

Part 5: Termination of Coverage

5.1 Termination of Group Coverage

This Certificate and the contract between a group and BCN will continue in effect for the period established by BCN and the group. The agreement continues from year to year, subject to the following:

- The group or BCN may terminate the Certificate with 30 days written notice. Benefits for all members of the group will terminate on the date the Certificate terminates.
- If the group terminates this Certificate, all rights to benefits end on the date of termination. BCN will cooperate with the group to arrange for continuing care of members who are hospitalized on the termination date.

5.2 Termination for Nonpayment

Nonpayment of Premium

- If a group or individual subscriber fails to pay the premium by the due date, the group or individual is in default. BCN allows a 30 day grace period, however, if the default continues, the group and its members, or the individual subscriber may be terminated.
- BCN will allow a 30 day grace period, however, if the group or individual is terminated, any benefits incurred by a member and paid by BCN after the termination will be charged to the group or the individual subscriber.

Nonpayment History

- BCN may refuse to accept an application for enrollment or may decline renewal of any member's coverage if the applicant or any member on the contract has a history of delinquent payment of premiums or copayments.

Nonpayment of Member Copay

- BCN may terminate coverage for any contract under the following conditions:
 - Members fail to pay copayments or other fees within 90 days of their due date, or
 - Members do not make and comply with acceptable payment arrangements with BCN to correct the situation.
- The termination will be effective at the renewal date of the Certificate. BCN will give reasonable notice of such termination.

5.3 Termination of a Member's Coverage

Coverage for any member may also be terminated for any of the reasons listed below. Such termination is subject to reasonable notice and grievance rights, if applicable:

- The member no longer meets eligibility requirements
- A contract is cancelled for nonpayment
- The group's coverage is cancelled
- Refusal to cooperate with BCN in pursuing subrogation
- A satisfactory physician-patient relationship cannot be established
- Providing false or misleading information or for withholding material information
- Fraud or misuse of the BCN ID card
- Acting in an abusive or threatening manner, being obstructive to staff or other patients or for intentionally misusing the BCN system

5.4 Extension of Benefits

All rights to BCN benefits end on the termination date **except**:

- Benefits will be extended for an authorized inpatient admission that began prior to the termination date.

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 patient is discharged.
- The benefits expire.
- The Primary Care Physician determines that the inpatient admission is no longer medically necessary.
- The patient becomes eligible for other coverage.

Part 6: Conversion and Continuation Coverage

6.1 Loss Because of Eligibility Change

If you no longer meet **eligibility** requirements for group coverage, you may apply for conversion to non-group coverage. There will be no lapse in coverage if the following events occur within 30 days after you lose eligibility for group coverage:

- You apply in writing.
- You are approved by BCN.
- You pay the applicable premium charges.

NOTE: Your non-group coverage may not be the same level of coverage as your prior group coverage.

6.2 Loss Because of Moving

If you no longer meet eligibility requirements because you move, but you are still eligible for coverage according to your group's guidelines, you have two choices. You must choose one of the following within 30 days to avoid a lapse in coverage:

- You may apply in writing for a waiver of the residency requirement. The waiver **must** be approved by BCN.
or
- You must transfer to your group's alternate carrier, if any.
If your group does not have an alternate carrier, you may apply for conversion coverage through Blue Cross Blue Shield of Michigan.

6.3 Loss of Coverage by Dependent

If a family dependent ceases to be eligible for coverage because of:

- the death of the subscriber,
- divorce from the subscriber,
- change of residence **or**
- loss of dependent status,

the dependent may apply for conversion coverage as outlined in Section 6.1. A minor or totally disabled dependent that is 19 years or older, may convert only as a dependent on a parent's conversion contract.

- If a family dependent member is no longer eligible to continue membership because he or she is eligible to enroll in Medicare, BCN will notify the member and convert the member's coverage to the applicable BCN Medicare program.

6.4 COBRA Coverage

COBRA is the continuation of group coverage, but at the member's expense, for members who lose eligibility. Most groups with over 20 employees are required by federal law to offer this coverage. The group is the administrator of its COBRA plan. If you have questions, contact the group.

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

If your group is subject to this federal law, and you are eligible for continuation coverage under the law, points 1, 2 and 3 below apply to you.

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 eligibility.
 - You are considered a group member for all purposes, including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
 - Continuation coverage and all benefits cease automatically under **any** of the following:
 - The period allowed by law expires.
 - The group stops offering BCN coverage.
 - You begin coverage under any other plan (with some exceptions).
 - You become eligible for Medicare.
 - You do not pay for your coverage fully and on time.
3. If you maintain uninterrupted coverage in good standing, you may change from continuation coverage to non-group conversion coverage at any time during the last six months of the period you were allowed for continuation coverage.
 - If you apply in writing and pay the premium to BCN before the last day of the period you were allowed for continuation coverage, there will be no lapse in coverage.
 - The non-group conversion coverage may not be the same level of coverage as your prior group coverage.
 - A minor or totally disabled dependent that is 19 years or older, may convert only as a dependent on a parent's conversion contract.

Part 7: General Provisions

7.1 Notice

Any notice that BCN is required to give its members will be

- In writing;
- Delivered personally or sent by U.S. Mail; and
- Addressed to the subscriber's last address of record

7.2 Change of Address

You, the subscriber, must notify BCN immediately of any change of address for yourself or any dependent. If you do not notify BCN of a change of address outside the service area within a reasonable period of time, your contract may be cancelled.

7.3 Headings

The titles and headings in your Certificate are not a part of the Certificate. They are intended to make your Certificate easier to read and understand.

7.4 Governing Law

This Certificate of coverage is made and will be interpreted under the laws of the state of Michigan.

7.5 Execution of Contract of Coverage

When you, the subscriber, sign the BCN application form, you are agreeing to all terms, conditions and provisions of this Certificate.

7.6 Assignment

The benefits provided under this Certificate are for the personal benefit of the members. They cannot be transferred or assigned to another person.

If any member tries to assign this Certificate to another person, all rights will be automatically terminated. BCN will not pay any provider except under the provisions of this Certificate.

7.7 BCN Policies

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

7.8 Arbitration and Litigation

- You may not bring any action or lawsuit against BCN under this Certificate unless you give BCN 30 days advance notice.
- You may not bring any action or lawsuit against BCN under this Certificate more than two years after a claim has arisen.
- You may not bring any action or lawsuit against BCN unless you have first followed the BCN internal grievance process.

7.9 Your Contract

Your contract with BCN consists of all of the following:

- *Your Benefits and General Provisions* booklets (the “Certificate”)
- The agreement between the group and BCN (for group coverage)
- Any applicable riders
- The application signed by the subscriber
- BCN identification card

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

7.10 Waiver by Agents

No agent or any other person, except an executive officer of BCN, has the authority to do any of the following:

- Waive any conditions or restrictions of this Certificate
- Extend the time for making payment
- Bind BCN by making promises or representations or by giving or receiving any information.

7.11 Amendments

- This Certificate and the agreement between the group and BCN are subject to amendment, modification or termination.
- Such changes must be made in accordance with the terms of this Certificate or by mutual agreement between the group and BCN, with regulatory approval, if required.

7.12 Major Disasters

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

If facilities and personnel are not available, causing delay or lack of services, there is no liability or obligation to perform covered services under such circumstances.

Such circumstances include:

- complete or partial disruption of facilities
- disability of a significant part of facility or BCN personnel, etc.
- war
- riot
- civil insurrection
- labor disputes not within the control of BCN

7.13 Obtaining Additional Information

The following information is available from BCN by writing to BCN at 20500 Civic Center Drive, Southfield, Michigan 48076.

- The current provider network in your service area
- The professional credentials of the health care providers who are participating providers with BCN, including participating providers who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain
- The names of participating hospitals where individual participating physicians have privileges for treatment
- How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care provider
- Information about the financial relationships between BCN and a participating provider

Blue Care Network

BCN 10 Certificate

Your complete **Certificate of Coverage** includes the two booklets listed below plus any riders that we issue.

- **Your Benefits** (this booklet) is a detailed description of your BCN health care coverage. It has two parts:
 - **Part 1** describes your benefits.
 - **Part 2** explains the exclusions and limitations to your benefits.
- **General Provisions**, a partner booklet, describes the rules of your BCN health coverage plan.

IMPORTANT INFORMATION

- BCN is a health maintenance organization that operates on a direct service basis. It is not an insurance company.
- We cover the benefits listed in your Certificate **only**:
 - when they are provided in accordance with your Certificate, and
 - when they are preauthorized or approved by BCN, except for emergency care (See Section 1.05.)
- All benefits are subject to the limitations and exclusions listed in Part 2 of this booklet.
- The benefits listed in your Certificate and Riders are covered only when they are medically necessary. (Medical necessity is decided by your Primary Care Physician and BCN's Medical Director.)
- You are responsible for copayments for many of the benefits listed. (See Section 1.01.)

Definitions

These definitions will help you understand the terms used in this booklet.

BCN is Blue Care Network, the health maintenance organization in which you are enrolled.

Benefit is a covered health care service available to a member as described in this Certificate.

Certificate is the two booklets we issue to you that describe your coverage and any riders we issue that change your coverage:

- **Your Benefits** (this booklet) is a detailed description of your health care benefits, including exclusion and limitations.
- **General Provisions** describes the rules of your BCN health coverage plan.

Geographic Region is the counties covered by your BCN regional office.

Hospital is a state-licensed, acute-care facility that provides continuous, 24-hour inpatient medical, surgical or obstetrical care. It is not primarily a nursing care facility, rest home, home for the aged or a facility to treat substance abuse, psychiatric disorders or pulmonary tuberculosis.

Inpatient Service is a service provided during the time a patient is admitted to a hospital or skilled nursing facility.

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

Medical Office (or "office") is a walk-in facility or office operated and staffed by BCN-affiliated physicians and personnel who serve BCN members.

Member is the subscriber or an eligible dependent entitled to benefits under this Certificate.

Preauthorized Service is health care coverage described in your Certificate and authorized or approved by your Primary Care Physician and BCN prior to obtaining the care or service, **except** in an emergency.

Primary Care Physician is a licensed medical doctor (MD) or doctor of osteopathy (DO) affiliated with BCN as a Primary Care Physician and located in your geographic region.

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

Referral is a service preauthorized by BCN and performed by a Referral Physician.

Rider is a change to the Certificate (addition, deletion or amendment) that is purchased by the group. When there is a conflict between the Certificate and a Rider, the Rider takes precedence.

Service Area is the geographic area that is served by BCN through approval by state authorities.

Skilled Nursing Facility is a state-licensed, certified nursing home that is affiliated with BCN and that provides a high level of specialized care to members. It is an alternative to extended hospital stays.

Subscriber is the eligible person who has enrolled for health care coverage with BCN. This person is the one responsible for payment of health care coverage premiums or whose employment is the basis for coverage eligibility. This person is also known as a "member."

Other **members** are those dependents of the subscriber who are eligible for coverage.

NOTE: See **General Provisions** for eligibility requirements for subscribers and dependents.

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Part 1: Your Benefits

1.01 Copayments

Benefit Copay

You are responsible for copayments (“copay”) for many of the benefits listed. This may be a set dollar amount or a percentage of the fee. You pay the specified amount or amounts at the time you receive the services.

Hospital Copay

Your hospital copay is 25% of all hospital-billed fees for **facility, professional and related services** you receive while you are an **inpatient** and when you have **outpatient surgery**.

Hospital Copayment Maximum

All copayments you make for hospital-billed fees apply to a hospital copayment maximum. Once you reach the maximum, you do not pay copays for these hospital-billed fees for the rest of the year.

Your hospital copayment maximum per year is:

- \$1,000 per individual
- \$2,000 per contract

Exceptions

For some hospital services, you do **not** pay the regular hospital copayment, but you **do** pay a specific **benefit** copayment.

The following benefit copayments do **not** apply to your hospital copayment maximum:

- Non-surgical outpatient hospital services (1.04)
- Emergency Room visits (1.05)
- Urgent care visits (1.05)
- Infertility services (1.09)
- Pregnancy Terminations (1.09)
- Sterilizations (1.09)
- Outpatient mental health services (1.12)
- Substance abuse services (1.13)
- Outpatient rehabilitation (1.14)
- Reduction Mammoplasty (1.18)
- Temporomandibular Joint Syndrome (TMJ) treatment (1.20)

- Orthognathic surgery (1.21)
- Weight reduction services (1.22)

NOTE: If we issue a rider that changes the copay listed in this booklet, the copay in the rider will apply.

1.02 Professional Services

The following services are covered when they are medically necessary and provided by your Primary Care Physician or a Referral Physician.

- a) **Office Visits, occasionally physicians will render office visits at a hospital site.**

Copayment: \$10 for each office visit

- b) **Maternity Care** - including prenatal and postnatal visits

Copayment: \$10 for each office visit

- c) **Home Visits**

Copayment: \$10 for each visit

- d) **Inpatient Professional Services** – Physician services provided while the member is an inpatient in a hospital or skilled nursing facility and billed by the physician – covered in full **except** for services listed in this Certificate that have a specific copay.

NOTE: If these services are billed by the hospital, the hospital copay applies.

- e) **Allergy Care**

Copayment: 50% for testing, serum and related office visits; \$5 per visit for allergy shots

1.03 Inpatient Hospital Services

The following services are covered with a 25% copay when they are medically necessary and preauthorized by your PCP and BCN, **unless** they are listed elsewhere in this Certificate with a specific copay.

- a) **Semi-private room and board, general nursing services and special diets**

NOTE: Private room is covered only when medically necessary and preauthorized by BCN.

- b) **Operating and other surgical treatment rooms, delivery room and special care units**

- c) **Anesthesia, laboratory, radiology and pathology services**

- d) **Chemotherapy, inhalation therapy and hemodialysis**

- e) **Physical, speech and occupational therapy**

- f) **Other inpatient services and supplies necessary for the treatment of the member.**

- g) **Maternity care and routine nursery care of newborn** (See Section 2.13 for exclusions.)

NOTE: Under federal law, we may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

48 hours following a vaginal delivery

96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending provider, e.g., your physician or **certified nurse midwife**, after consultation with the mother, discharges the mother or newborn earlier.

Copayment: 25% of all inpatient fees; these copays apply to your hospital copay maximum. (See Section 1.01.)

1.04 Outpatient Hospital Services

Outpatient services are covered when they are medically necessary and preauthorized by your Primary Care Physician and BCN.

Copayment:

- Outpatient surgery: 25% of hospital-billed fees (applies to your hospital copay maximum)
- Non-surgical services: \$10 (**does not** apply to hospital copay maximum)

NOTE: There is no copay for lab, X-rays or pathology. (See Section 1.01.)

1.05 Emergency Care

Definitions:

- **Medical emergency** - the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- **Accidental injury** – a traumatic injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.
- **Emergency services** – services to treat emergency conditions as described above.
- **Stabilization** – the point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during your transfer.

Coverage:

Emergency services are covered up to the point of stabilization when they are medically necessary and needed immediately to treat a condition that meets the definition of an emergency condition as described above or if the Primary Care Physician directs the patient 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.

Emergency services are no longer payable as emergency services at the point of the patient's stabilization as defined above.

Follow-up care, such as removal of stitches and dressings, is covered only when preauthorized by your Primary Care Physician and BCN.

Copayment:

- \$25 for emergency services provided in a hospital. **(Note: This copayment does not apply to your hospital copayment maximum)** If you are admitted as an inpatient as a result of the emergency, there is no emergency room copay. Instead, you would be responsible for a 25% inpatient hospital copay.
- \$10 for emergency services in a non-hospital based urgent care center **(Note: This copayment does not apply to your hospital copayment maximum)**
- \$10 for emergency services by a physician in a physician's office

Out-of-Area Emergency Hospitalization

If you are hospitalized in a **non-BCN-affiliated** facility or one that is **outside of your geographic region**, we may require that you be transferred to an affiliated hospital or another facility within your geographic region as soon as you are stabilized.

1.06 Ambulance

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

The following ambulance services are covered:

- **Non-emergency** ground ambulance services when preauthorized by your Primary Care Physician and BCN
- **Emergency** ground ambulance services when:
 - You are admitted as an inpatient to the hospital immediately following emergency room treatment
 - The services are necessary for management of shock, unconscious-ness, heart attack or other condition requiring active medical management
 - The services are needed for emergency delivery and care of a newborn and mother. The services are **not** covered for normal or false labor.
 - The ambulance is ordered by an employer, school, fire or public safety official, and you are not in a position to refuse.
- **Air ambulance** for emergency transport is covered to the nearest hospital equipped to treat your condition **only** when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and must be verified by the records of the physician who treats you and by the ambulance company.

Copayment: \$25 for each ambulance service

1.07 Diagnostic and Therapeutic Services and Tests

We cover medically necessary therapeutic and diagnostic laboratory, pathology and radiology services, and other procedures for the diagnosis or treatment of a disease, injury or medical condition. These are covered when they are preauthorized by your Primary Care Physician and BCN.

These services are covered in full **except** when they are listed in this Certificate with a specific copay.

1.08 Preventive and Early Detection Services

We cover the following services when provided or referred by your Primary Care Physician:

- a) **Periodic well-child exams, health assessments and adult physical examinations** at intervals set by BCN in relation to your age, sex and medical history (See Section 2.04 for exclusions).

Copayment: \$10 for each office visit even if you receive more than one service during that office visit.

- b) Pediatric and adult **immunizations** in accordance with accepted medical practice and when necessary for purposes of travel.

Copayment: Immunizations are covered in full. A \$10.00 office visit copay may apply.

- c) **Nutritional advice, counseling and supervision**

Copayment: \$10 for each office visit even if you receive more than one service during that office visit.

- d) **Vision and hearing screening** performed at your Primary Care Physician's office to determine need for a vision or hearing exam. If a medical problem is detected during the screening, your Primary Care Physician will coordinate further medical treatment.

Copayment: \$10 for each office visit even if you receive more than one service during that office visit.

NOTE: Certain health education and health counseling services may be arranged through your Primary Care Physician, but are not covered; they are payable by the member. **Examples:** birthing classes, weight loss programs, smoking cessation programs, aerobics classes

1.09 Reproductive Care and Family Planning Services

This benefit includes:

- Infertility
- Sterilization
- Termination of Pregnancy
- Reproductive Care and Family Planning
- Genetic Testing

a. Infertility

We cover diagnosis, counseling and treatment of infertility **except** as stated below and in Section 2.13. Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment may begin only when BCN determines they are in accordance with generally accepted medical practice.

Copayment: 50% of all fees associated with infertility diagnostic work-up procedures and treatment, including prescription drugs, and all facility, professional and related services

(Note: This copayment does not apply to your hospital copayment maximum)

Exclusions:

- 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

We cover adult sterilization procedures, including inpatient, outpatient and office-based services.

Copayment: 50% of all fees associated with facility, professional and related services. **(Note: This copayment does not apply to your hospital copayment maximum)**

Exclusion:

- Reversal of surgical sterilization

c. Termination of Pregnancy

We cover elective first trimester (3 months) termination of pregnancy – one in each two-year period of membership

Copayment: 50% of all fees associated with facility, professional and related services. **(Note: This copayment does not apply to your hospital copayment maximum)**

d. Reproductive Care and Family Planning

Coverage:

We cover the following services when they are provided in accordance with generally accepted medical practice:

- History
- Physical exam
- Lab tests
- Advice and medical supervision related to family planning

Copayment: \$10 for each office visit

e. Genetic Testing

We cover medically indicated genetic testing and counseling when they are preauthorized by BCN and provided in accordance with generally accepted medical practice.

Copayment: \$10 for each office visit

1.10 Skilled Nursing Facility Services

Up to 45 days skilled nursing care in any calendar year in a skilled nursing facility are covered in full when medically necessary for recovery from surgery, disease or injury. This benefit includes hospice care in a skilled nursing facility. The care must be preauthorized by your Primary Care Physician and BCN.

NOTE: We do **not** cover basic custodial care.

1.11 Home Care Services

Home Care Services include skilled nursing care, hospice care and other health care services approved by BCN when they are performed in the patient's home. Home Care Services are covered when BCN determines they are medically necessary.

- This benefit does **not** include any housekeeping services.
- These services are **not** covered for the purpose of providing long-term custodial care.

Copayment: \$10 each day a visit occurs

1.12 Mental (Behavioral) Health Care

All mental health care services must be provided by BCN affiliated providers and be preauthorized and arranged through BCN **except** in an emergency. (See Section 1.05.)

Coverage:

- Outpatient evaluation, crisis intervention and short-term therapy, up to 20 visits per member per calendar year.
 - Covers only conditions that are not chronic and that are likely to show significant improvement within the 20 visits.

Copayment: 50% of the fees for each visit. (**Note: This copayment does not apply to your hospital copayment maximum**)

Exclusions:

Chronic mental health (see Section 2.11), court-related services that do not meet requirements for mental health coverage (see Section 2.12) and Marital counseling services are not covered.

1.13 Substance Abuse Services

All substance abuse treatment must be provided by BCN-affiliated providers and preauthorized by BCN **except** in an emergency. (See Section 1.05.)

Definitions:

- **Detoxification** means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detoxification can occur in an inpatient, outpatient or residential setting.
- **Intermediate Substance Abuse Treatment** means services provided in a full day (24-hour) residential setting to a member who is dependent on and/or abusing alcohol or drugs (or both). Services may include counseling, detoxification, medical testing, diagnostic evaluation and referral for other services.
- **Outpatient Substance Abuse Treatment** means outpatient visits for a member who is dependent on and/or abusing alcohol or drugs (or both). The visit may include counseling, detoxification, medical testing, diagnostic evaluation and referral for other services.

Coverage:

IMPORTANT: Fees for any combination of the types of service listed above apply to the State mandated annual dollar minimum adjusted annually in accordance with the annual average percentage increase or decrease in the Consumer Price Index for the past 12-month period ending the preceding December 31. When this amount is reached, intermediate and outpatient substance abuse treatment will no longer be covered. However, detox services will still be covered, subject to the 50% copay.

The following services are covered:

- **Detoxification**
 - for acute conditions on an inpatient basis
 - for acute and non-acute conditions in an outpatient or intermediate setting

Copayment: 50% of all fees associated with facility, professional and related services. **(Note: This copayment does not apply to your hospital copayment maximum)**

- **Intermediate/Outpatient Substance Abuse Treatment**

One program in any 12-month period. This may include outpatient or intermediate services or a combination.

Copayment: 50% of all fees associated with facility, professional and related services **up to** the annual state-mandated amount. You are responsible for any fees in excess of this amount. **(Note: This copayment does not apply to your hospital copayment maximum)**

Exclusions: Chronic substance abuse (Section 2.11) and court-related services that do not meet the requirements for substance abuse coverage (Section 2.12) are not covered.

1.14 Outpatient Rehabilitation

Outpatient rehabilitation includes:

- Medical rehabilitation
- Physical therapy
- Occupational therapy
- Speech therapy

Short-term outpatient medical rehabilitation and physical, occupational and speech therapy are covered when they are medically necessary for a condition that can be expected to improve significantly within 60 consecutive days. These services must be preauthorized by your Primary Care Physician and BCN.

NOTE: Medical rehabilitation is a treatment for recovery from surgery, disease or injury. This also includes cardiac and pulmonary rehabilitation.

Copayment: \$10 for each covered visit

(Note: This copayment does not apply to your hospital copayment maximum)

Limitation: One period of treatment for any combination of therapies within 60 consecutive days is covered per medical episode.

General Exclusions Include but are not limited to:

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

Speech Therapy Exclusions Include:

- chronic conditions or congenital speech abnormalities
- learning disabilities
- deviant swallow or tongue thrust
- mild and moderate developmental speech or language disorders
- vocal cord abuse resulting from life-style activities

1.15 Durable Medical Equipment

Durable medical equipment (DME) is equipment that must be used primarily for medical purposes. It must be intended for repeated use and be useful primarily as a result of illness, injury and congenital defect.

Coverage: Rental or purchase of durable medical equipment is limited to the basic equipment. Any special features that are considered medically necessary must be preauthorized by BCN to be covered.

Copayment: 50% of the fee for the equipment

Limitations:

- The equipment must be considered durable medical equipment by BCN and must be appropriate for home use.
- You must obtain the equipment from BCN or a BCN-approved supplier.
- Your Primary Care Physician must prescribe the equipment, and it must be preauthorized by BCN.

- The equipment is the property of BCN or the supplier. When it is no longer medically necessary, you may be required to return it to the supplier.
- Replacement of DME is covered only when necessary to accommodate body growth, body change or normal wear.

Exclusions: The equipment listed below is not covered. (There may be additional equipment that is not covered.)

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless medically necessary for the patient and required so the patient can operate the equipment himself.
- Items that are not considered medical items
- Duplicate equipment
- Items for comfort and convenience (such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners, hot tubs, water beds, etc.)
- Physician's equipment (such as blood pressure cuffs and stethoscopes)
- Disposable supplies (such as sheets, bags, elastic stockings)
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills)
- Self-help devices that are not primarily medical items (sauna baths, elevators and ramps, special telephone or communication devices)
- Equipment that is experimental or for research
- Needles and syringes for purposes other than the treatment of diabetes
- Repair or replacement due to loss or damage
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and such equipment not intended for use in the home.

1.16 Prosthetics, Orthotics and Corrective Appliances

Definitions:

- **Prosthetic** devices help the body to function or replace a limb or body part after loss through an accident or surgery.
- **Orthotic** appliances are used to correct a defect of the body's form or function.
- **Corrective appliances** are items such as eyeglasses or contact lenses.
- **Artificial aids** are items such as cardiac pacemakers and artificial heart valves

A. Coverage - Prosthetics and Orthotics

Prosthetics and orthotics are covered for the basic item and any special features that are medically necessary and preauthorized by BCN.

Coverage is included for breast prostheses required following a mastectomy.

Replacement of the item is covered when necessary because of body growth, change or normal wear.

Copayment: 50% of the fee for the item

Limitations:

- The item must meet the BCN definition of a prosthetic or orthotic item.
- You must obtain the item from BCN or a BCN-approved supplier.
- The Primary Care Physician must prescribe the item, and it must be preauthorized by BCN.

Exclusion:

- Repair or replacement due to loss or damage is not covered.

B. Coverage – Corrective Appliances and Artificial Aids

These items are covered when they are medically necessary and preauthorized by BCN.

- Any implanted items such as cardiac pacemakers and artificial heart valves are covered in full.
- Prescription lenses (eyeglasses or contact lenses) are covered immediately following preauthorized surgery for eye diseases, such as cataracts, or to replace an organic lens that is missing from birth.

Copayment: 50% of the fee for the item

Limitation: You must obtain lenses through BCN or from a BCN-approved supplier.

Exclusions:

The following are **not** covered:

- Items such as:
 - Sports-related braces
 - Dental appliances
 - Hearing aids
 - Eyeglasses or contact lenses (except after surgery as listed above)
 - Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics
- Devices or appliances that are experimental or for research

1.17 Organ and Tissue Transplants

Organ or body tissue transplant is covered when:

- It is considered non-experimental in accordance with generally accepted medical practice, and
- It is medically necessary, and
- It is performed at a BCN-approved facility

(Coverage is provided for related antineoplastic drugs pursuant to Section 1.24 of this Certificate.)

For a preauthorized transplant, BCN also covers the necessary hospital, surgical, lab and X-ray services for a non-member donor, unless the non-member donor has coverage for such services.

Copayment: 25% (up to your hospital copay maximum)

1.18 Reconstructive Surgery

Definition:

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

- Correction of a birth defect that affects function.
- Breast reconstructive surgery following a mastectomy for treatment of cancer (including nipple reconstruction). This includes surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment for physical complications resulting from the mastectomy, including lymphedemas.
- Repair of extensive scars or disfigurement resulting from any covered surgery, disease, accidental injury, burns and/or severe inflammation

Coverage: Reconstructive surgery is covered only when it is medically necessary and preauthorized by BCN.

Copayment: 25% (applies to your hospital copayment maximum)

a. Reduction Mammoplasty (Breast Reduction Surgery)

Surgery for Reduction mammoplasty (breast reduction) is covered when it is medically necessary and preauthorized by BCN. All of the following criteria must be met:

- The member must have pain in the neck, upper back and/or shoulders. The pain should not be caused by another diagnosis.
- The member must participate in a six-week course of conservative therapy, which may include:
 - wearing an appropriate support bra
 - exercises
 - heat/cold treatments, and
 - taking non-steroidal anti-inflammatory agents or muscle relaxants when appropriate
- The member must have ulceration of the skin of the shoulder or shoulder grooving that has not responded to conservative treatment, including the support bra. There must be a rash between the pendulous breast and chest wall.
- The member must require resection/removal of 500 grams or more of tissue per breast at a minimum. BCN will not cover removal of less than 500 grams per breast.

Copayment: 50% of all fees associated with covered facility, professional and all related

services. (Note: This copayment does not apply to your hospital copayment maximum).

b. Male Mastectomy

Male mastectomy for the condition gynecomastia is covered when it is preauthorized by BCN. All of the following criteria must be met:

- The member is a male age 18 or older
- The tissue to be removed is glandular (not fatty tissue) and over 2 centimeters in size.
- The breast enlargement is not the result of obesity, adolescent changes, endocrine dysfunction, or effects of drug treatment which can be reversed if the treatment is discontinued.

Copayment: 50% of all fees associated with covered facility, professional and all related services. (Note: This copayment does not apply to your hospital copayment maximum).

1.19 Oral Surgery

NOTE: Also see Sections 1.20, 1.21 and 2.14.

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

- Treatment of fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw
- Oral surgery and dental services necessary for immediate repair of trauma to the jaw, natural teeth, cheeks, lips, tongue, roof and floor of the mouth.
- Dental anesthesia in an outpatient setting when medically necessary and approved by BCN.

NOTE: "Immediate" means treatment within 72 hours of the injury.

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

Copayment: \$10 for each office visit

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.

Copayment: 25% for hospital-billed fees (applies to hospital copayment maximum)

1.20 Temporomandibular Joint Syndrome (TMJ) Treatment

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

IMPORTANT: **Dental** services are **not** covered.

Coverage: Medical services and treatment for TMJ listed below are covered when they are medically necessary and preauthorized by BCN.

Covered services include:

- Office visits for medical evaluation and treatment
- Specialty referral for medical evaluation and treatment

- X-rays of the temporomandibular joint, including contrast studies
- Surgery to the temporomandibular joint including, but not limited to, condylectomy, meniscectomy, arthrotomy and arthrocentesis

Copayment: 50% of all fees associated with facility, professional and related services. **(Note: This copayment does not apply to your hospital copayment maximum)**

Exclusions:

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

1.21 Orthognathic Surgery

Definition: Orthognathic surgery is Oral surgery involving repositioning an individual tooth, arch segment or entire arch, usually done in conjunction with a course of orthodontic treatment.

Coverage: The services listed below are covered when they are medically necessary and preauthorized by BCN:

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

Copayment: 50% of all fees associated with professional, facility and related services. **(Note: This copayment does not apply to your hospital copayment maximum)**

Exclusion: Orthodontic treatment is **not** covered for any purpose, **including** orthognathic conditions.

1.22 Weight Reduction Procedures

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

- The services are provided because of an underlying medical condition, and
- The member meets BCN medical criteria for having the procedure, and
- BCN preauthorizes procedures as medically necessary, and
- The services are not considered to be experimental or investigational, and
- The services are in accordance with generally accepted medical practice.

Copayment: 50% of all fees associated with weight reduction procedures, including related facility and professional services. **(Note: This copayment does not apply to your hospital copayment maximum)**

1.23 Hospice Care

Hospice care in a licensed hospice facility in the home or in a skilled nursing facility may be covered. This care must be medically necessary and preauthorized by BCN.

- Inpatient hospice care is under the skilled nursing facility benefit (Section 1.10).
- Hospice care in the home is under the home care benefit (Section 1.11).

Copayment: \$10 each day a visit occurs

1.24 Antineoplastic Drugs

We cover a federal food and drug administration approved drug used in antineoplastic and drug administration, approved drug used in antineoplastic therapy and the reasonable cost of its administration.

Coverage is provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval from the federal food and drug administration **if all** of the following conditions are met:

- The drug is ordered by a physician for the treatment of a specific type of neoplasm.
- The drug is approved by the federal food and drug administration for use in antineoplastic therapy.
- The drug is used as part of an antineoplastic drug regimen.
- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
- The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

1.25 Intractable Pain

Definition:

Intractable Pain is a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by 1 or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

Coverage: is provided for facility and professional services for the evaluation and treatment of intractable pain when determined to be medically necessary and provided or authorized by your Primary Care Physician.

Copayment: \$10 for each office visit. Inpatient care copayment: 25% for hospital billed fees (applies to hospital copayment maximum).

1.26 Out-of-Area Coverage

You are covered when traveling out-side of the BCN service area for emergency services that meet the conditions described in Section 1.05 of this schedule of benefits.

Part 2: Exclusions and Limitations

This section lists the exclusions and limitations of your BCN10 Certificate .

2.01 *Unauthorized and Out-of-Plan Services*

Except for emergency care as specified in Section 1.05 of this booklet, health, medical and hospital services listed in this Certificate are covered **only** if they are:

- provided by a BCN-affiliated provider and
- preauthorized by BCN.

Any other services will not be paid for by BCN either to the provider or to the member.

2.02 *Facility Admission Prior to Effective Date*

If a member must be admitted to a hospital, skilled nursing or residential substance abuse/psychiatric facility **before** the member's effective date of coverage, coverage for the inpatient or facility care will begin on the effective date of coverage **only if**:

- The member has no continuing coverage under any other health benefits contract, program or insurance;
- BCN is notified of the admission prior to the effective date and the medical management of the member is transferred to a BCN Primary Care Physician before or on the effective date, and
- The Primary Care Physician authorizes the care as medically necessary.

2.03 *Services that are not Medically Necessary*

Services that are not medically necessary are not covered, unless specified in the Certificate. The final determination of medical necessity is the judgment of the Primary Care Physician and the BCN Medical Director.

2.04 *Noncovered Services*

Office visits, exams, treatments, tests and reports for any of the following are **not** covered:

- Employment
- Licenses
- Insurance
- Travel (immunizations for purposes of travel are a covered benefit)
- School purposes
- Legal proceedings such as parole, court and paternity requirements

2.05 *Cosmetic Surgery*

Cosmetic surgery is surgery primarily to improve appearance. We do not cover cosmetic surgery or any of the related services, such as pre- or post-surgical care, follow-up care, reversal or revision of the surgery or treatment for complications.

2.06 Prescription Drugs

We do not cover any outpatient prescription drugs, over-the-counter drugs or products, or any medicines incidental to outpatient care **except** for infertility drugs (as stated in Section 1.09), chemotherapy (as stated in Section 1.03 (d) and 1.07) and antineoplastic drugs (as stated in Section 1.24)

2.07 Military Care

We do not cover any care for diseases or disabilities connected with military service if you are legally entitled to obtain services from a military facility, and such a facility is available within a reasonable distance.

2.08 Custodial Care

We do not cover any custodial care, i.e., care that is primarily for maintaining the member's basic needs for food, shelter and clothing. This means that custodial care is not covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and skilled nursing care.

2.09 Comfort Items

We do not cover any personal or comfort items, such as telephone, television, etc.

2.10 Research or Experimental Services

We do not pay for services, treatment or drugs (collectively referred to as "services") that are experimental or investigational. All facility, ancillary and physician services, including diagnostic tests, which are related to experimental or investigational procedures, are not payable.

Definitions:

Clinical Trial

A study conducted on a group of patients to determine the effect of a treatment. Clinical trials generally include the following phases:

- Phase I - a study conducted on a small number of patients to determine what the side effect(s) and appropriate dose of treatment may be for a certain disease or condition.
- Phase II - a study conducted on a larger number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III - a study conducted on a much larger group of patients to compare the new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Experimental or Investigational

A service which has not been scientifically demonstrated to be as safe and effective for treatment of the patient's condition as conventional or standard treatment.

Service

Any surgery, care, treatment, supplies, devices, drugs or equipment given by a health provider to diagnose or treat disease, injury, condition or pregnancy.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES

The BCN Medical Director is responsible for determining whether the use of any service is experimental or investigational. The service may be determined to be experimental or investigational when:

- A written study protocol, clinical trial or plan indicates the service or treatment is experimental or investigational;
- The service is delivered as part of or in the context of a clinical trial;
- The service is delivered pursuant to oversight by an institutional review committee or human subjects (or comparable) committee;
- The service has not received approval by the appropriate regulatory body, if applicable;
- There is no evidence that, at the time administered, the service is generally accepted by the medical community; or
- A written informed consent is used by the treating provider which refers to the service as experimental, investigational or other than conventional or standard therapy.

The BCN Medical Director may use some or all of the following information in the evaluation process:

- Scientific data such as controlled studies in peer reviewed journals or medical literature
- Information from established national or local industry groups
- Information from local and national medical societies or other appropriate professional societies, organizations or committees
- Information obtained from governmental bodies, including but not limited to the Food and Drug Administration (FDA), and other governmental and regulatory agencies
- Accepted national standards of practice by the medical profession
- Information obtained from an Institutional Review Board of a hospital or sponsoring medical facility
- Information from the BCN Member's Primary Care Physician

2.11 Chronic Mental Health; Chronic Substance Abuse

Definition: A member may be evaluated and determined to have a chronic substance abuse problem or chronic mental health condition. This means that the condition is not likely to improve as a result of the treatment available under Sections 1.12 and 1.13.

- **Outpatient** services for **acute** episodes of such a chronic condition are covered as listed in Sections 1.12 and 1.13.

- Services such as long-term therapy, custodial care, psychoanalysis and any other services that are not expected to change the chronic condition significantly are **not covered**.
- We do not cover any services that are provided in connection with emotional and personality disorders and illness unless they are classified as such in the current version of *International Classification of Disease, Clinical Modification*.

2.12 Court-Related Services

- We do not cover pretrial and court testimony, court-ordered exams that do not meet BCN requirements for coverage and the preparation of court-related reports.
- We do not cover court-ordered treatment for substance abuse or mental illness except as specified in Sections 1.12 and 1.13.

2.13 Elective Procedures

The following procedures are not covered:

- Reversal of surgical sterilization
- 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
- Transsexual surgery and related preparatory treatment
- Services provided by a lay-midwife and home births

2.14 Dental Services

We do not cover dental services, dental prostheses, replacement of teeth, X-rays, anesthesia for dental procedures or oral surgery except as specifically stated in Section 1.19.

2.15 Services Covered Through Other Programs

We do not cover any services that are available to you under the following circumstances:

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or Certificate
- Under any other policy, program, contract or insurance as stated in *General Provisions*, Part 3, "Other Party Liability." (*General Provisions* is the booklet that describes the rules of your BCN health coverage plan.)
- Under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, **except** where your BCN 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.

2.16 Alternative Services

Any alternative service, such as acupuncture, herbal treatments, massage therapy, therapeutic touch, aroma-therapy, is not covered.

2.17 Vision Services

The following vision services or items are not covered:

- Radial keratotomy
- Laser-Assisted in situ Keratomileusis (LASIK)
- Routine vision exams
- Refractions, unless medically necessary
- Glasses, frames and contact lenses except as specified in Section 1.16

2.18 Inpatient Mental Health Care

Your Certificate does not cover inpatient mental health care.