Certificate of Coverage

1. General conditions

1.01 This *Certificate of Coverage* is issued to persons who have enrolled in Blue Cross Complete through the Michigan Department of Health and Human Services. By enrolling and accepting this Certificate, the Member agrees to abide by the rules of Blue Cross Complete as explained in this Certificate.

1.02 Blue Cross Complete of Michigan is a State-approved health maintenance organization. Blue Cross Complete is an independent licensee of the Blue Cross Blue Shield Association. The Association allows Blue Cross Complete to use the Blue Cross Blue Shield service mark in Michigan. Blue Cross Complete is not a contracted agent of the Association. Only Blue Cross Complete can be held accountable or liable to its members for the obligations within this contract. Blue Cross Complete is solely responsible for its own debts and other obligations.

1.03 This *Certificate of Coverage* states the terms of enrollment, membership, and coverage for which a Medicaid recipient may receive Blue Cross Complete health benefits. Appendix A lists the benefits that members may receive. It also includes limitations and exclusions.

1.04 GOVERNING LAWS: This Certificate is made and shall be interpreted under the laws of the state of Michigan.

1.05 WAIVER BY AGENTS: No agent or person, except an authorized officer of Blue Cross Complete, can waive any conditions or restrictions of this Certificate. No agent or person can bind Blue Cross Complete by making a promise or representation, or by giving or receiving any information. No change in this Certificate is valid unless amended in writing and signed by an authorized officer.

1.06 POLICY AND PROCEDURES: Blue Cross Complete may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Certificate.

1.07 ASSIGNMENT: All rights of a Member to receive benefits and services are personal, granted only to the Member, and may not be assigned to a third party.

1.08 HEADINGS: The headings and captions in this Certificate are not to be considered as part of the Certificate and are inserted only for convenience.

1.09 NOTICE: Any notice given by Blue Cross Complete in this Certificate shall be given to members in writing. The notice will be hand-delivered, or mailed with postage prepaid by BCC and addressed to the member(s) at the address of record on file with Blue Cross Complete.

1.10 LEGAL ACTIONS: No action for recovery may be brought regarding this policy prior to 60 days after providing written proof of loss as required by this policy. No such action shall be brought after three years following the time written proof of loss is required to be furnished.

2. Definitions

2.01 AMBULATORY SURGERY means surgery performed in an operating room at a hospital or freestanding surgical center without overnight admission. Procedures routinely performed in physicians' offices are not considered ambulatory surgery.

2.02 APPROVED FACILITY means a facility that provides medical or other services to Blue Cross Complete Members and has entered into an agreement with Blue Cross Complete to do so.

2.03 ATTENDING PHYSICIAN means any physician who, upon appropriate referral by a primary care physician or authorization by Blue Cross Complete, is responsible for the care of Blue Cross Complete Members in inpatient hospital or ambulatory surgery facilities.

2.04 AUTHORIZED SERVICE means any health care service which is a benefit under the Certificate and which has been provided or arranged by a primary care physician or his or her designee and/or authorized by the Blue Cross Complete Medical Director to be provided by another provider. An authorized service may be referred to in this document as a covered service.

2.05 BENEFITS are the health care services described in this *Certificate of Coverage* and required under Michigan law or by MDHHS.

2.06 CERTIFICATE OF COVERAGE (or Certificate) is the statement of covered benefits, including the terms of enrollment and covered services. *Certificate of Coverage* may also be referred to as the Certificate.

2.07 CONTRACT consists of the Blue Cross Complete *Certificate of Coverage*, including: General Conditions, Definitions, Limitations and Exclusions in its entirety, member ID cards, forms and questionnaires completed by the Member. The contract also consists of any authorized amendments, riders, or endorsements.

2.08 CONTRACT YEAR means the 12-month period beginning with the effective date of the contract between MDHHS and Blue Cross Complete.

2.09 CONTRACTED HOSPITAL means a hospital which has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed to provide covered services to Blue Cross Complete Members in accordance with the terms and conditions of the contract. A contracted hospital also may be referred to as a participating hospital or a network hospital.

2.10 CONTRACTED PHYSICIAN means a physician who has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed. A Contracted Physician may be employed by a contracted hospital or may participate in a physician group or PHO which has signed a contract to provide covered services to Blue Cross Complete Members. A Contracted Physician also may be referred to as a participating physician or a network physician.

2.11 CONTRACTED PROVIDER means a provider who has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed to provide covered services to Blue Cross Complete Members in accordance with the terms and conditions of the contract. A contracted provider also may be referred to as a participating provider.

2.12 COVERED SERVICE(S) means the comprehensive health care services delivered under the terms and conditions for their delivery described in the *Certificate of Coverage*.

2.13 CUSTODIAL CARE is provided by persons without professional health care skills or training, primarily for the purpose of meeting personal needs such as bathing, walking, dressing, and eating.

2.14 DURABLE MEDICAL EQUIPMENT is equipment that is able to withstand repeated use, is customarily used to serve a medical purpose, and is not useful to a person in the absence of illness or injury. Examples include canes, crutches, and bed rails.

2.15 EFFECTIVE DATE is the date the Member is entitled to receive covered services pursuant to this Contract as determined by MDHHS.

2.16 EMERGENCY SERVICES means Medically necessary services provided to an enrollee with sudden, acute severe medical symptoms or severe pain that could likely result in:

- Serious harm to the enrollee's health, or in the case of a pregnant woman, her health or her unborn child's health,
- Serious damage to a body function, organ, or part.

Further, emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider qualified under this title.
- Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition.

2.17 ENROLLEE is an individual determined by MDHHS to be entitled to receive health care services under this *Certificate of Coverage*.

2.18 EXPERIMENTAL, INVESTIGATIONAL OR RESEARCH MEDICAL, SURGICAL CARE DRUG, DEVICE, TREATMENT, OR PROCEDURE

This means a drug, device, treatment, or procedure meeting one or more of the following criteria:

- It cannot be lawfully marketed, without the approval of the U.S. Food and Drug Administration and such approval has not been granted at the time of its use or proposed use; or
- It is the subject of a current investigational new drug or new device application on file with the FDA; or
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
- It is being provided pursuant to a written protocol describing the determination of safety, efficacy or efficiency in comparison to conventional alternatives.
- It is described as experimental, investigational or research by informed consent or patient information documents; or
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS) or successor agencies, or of a human subjects (or comparable) committee; or
- The predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment, investigation or research is necessary in order to define safety, toxicity, effectiveness or efficiency compared with conventional alternatives.

(Antineoplastic drug therapy shall be provided in accordance with Michigan law.)

2.19 FEE SCHEDULE means the schedule of fees that Blue Cross Complete pays to contracted providers for services and benefits under this Certificate.

2.20 HEARING AID is an electronic device worn for the purpose of amplifying sound and assisting the physiological process of hearing.

2.21 HOMEBOUND means a medical condition that prevents the patient from leaving home.

2.22 HOME HEALTH AGENCY is an organization licensed or certified pursuant to the laws of the state of Michigan as a home health agency and which has entered into an agreement with Blue Cross Complete to provide covered services to Members.

2.23 HOME HEALTH CARE means part-time skilled health care provided for homebound Members in the home for the treatment of an illness or injury, for medical conditions which are not long-term or chronic in nature.

2.24 HOSPICE CARE means services that are primarily used to provide pain relief, symptom management, and supportive services to the terminally ill and their families.

2.25 Blue Cross Complete of Michigan is authorized by the state of Michigan to arrange for the provision of health care services as a health maintenance organization.

2.26 Blue Cross Complete of Michigan is the name of the health care plan described in this *Certificate of Coverage*. Blue Cross Complete of Michigan may be referred to in this document as Blue Cross Complete, Plan, Health Plan or as the Medicaid Plan.

2.27 MEDICAID FAIR HEARING PROCESS means a process that exists at the Michigan Department of Health and Human Services that a Member may use to raise any concerns about any Blue Cross Complete decision under this Certificate. The Medicaid Fair Hearing Process is described in the *Member Handbook*.

2.28 MEDICAL DIRECTOR is a Michigan licensed physician designated by Blue Cross Complete to provide medical management and related services on behalf of Blue Cross Complete. As used in the Certificate, the term shall include any individual designated by the Medical Director to act on his or her behalf.

2.29 MEDICALLY NECESSARY means services and supplies furnished to a Member when and to the extent the Blue Cross Complete Medical Director or his or her designee determines that they satisfy all of the following criteria:

- They are medically required and medically appropriate for the diagnosis and treatment of the Member's illness or injury.
- They are consistent with professionally-recognized standards of health care.
- They do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the Member's illness or injury.

The fact that a physician may have prescribed, ordered, recommended, or approved the provision of certain services to the Member does not necessarily mean that such services satisfy the above criteria.

2.30 MEMBER means an individual entitled to receive benefits under this Certificate.

2.31 Through the MEMBER APPEALS PROGRAM a member can submit a concern about Blue Cross Complete, its providers or health care professionals. The MAP provides for a response following the procedures described in the *Member Handbook*.

2.32 NONAUTHORIZED SERVICE means any health care service, which hasn't been provided or arranged by the primary care physician or his or her designee, or hasn't been authorized by Blue Cross Complete to be provided by another provider.

2.33 NONCOVERED SERVICE means any health care service excluded as a benefit under this Certificate.

2.34 NONPLAN PROVIDER means any health care professional or provider who is not party to a contract with Blue Cross Complete to provide services to Medicaid members.

2.35 ORTHOTIC DEVICE is an external device which is designed to correct or assist in the prevention of a bodily defect either of form or function.

2.36 PLAN means the Blue Cross Complete Medicaid Plan.

2.37 PRESCRIPTION means any physician or licensed practitioner order for a medicinal substance which under the Federal Food, Drug, and Cosmetic Act is required to bear on the packaging label the following legend: "Caution: Federal Law prohibits dispensing without a prescription."

2.38 A Primary Care Physician (PCP) is the contracted doctor who provides or coordinates a Member's health care through referrals to other providers, professionals, or facilities. A PCP's specialty may be Family Practice, General Practice, Internal Medicine, OB-GYN, or Pediatrics. A specialist may act as a PCP when the Member's medical condition should be managed by a specialist and when approved by Blue Cross Complete.

2.39 PROSTHETIC DEVICE is a device which aids body functioning or replaces a limb or body part.

2.40 RESTORATIVE HEALTH SERVICES means intermittent or short-term rehabilitative nursing care that may be provided in or out of a health care facility.

2.41 SERVICE AGREEMENT is the contract between Blue Cross Complete of Michigan and the Michigan Department of Management and Budget, Acquisition Services, which establishes the scope of benefits being purchased, the criteria for eligibility, as well as the underwriting and administrative agreements between the parties.

2.42 SERVICE AREA means the geographical area in which Blue Cross Complete is authorized by state authorities to provide or arrange for the provision of health services to Members by network providers.

2.43 Skilled care is a service recommended by a doctor that requires the special skills of qualified technical or health personnel. The care must be provided directly by or under the supervision of skilled nursing or rehab personnel. This assures the safety of the Member and ensures the medically desired result is reached.

2.44 SKILLED NURSING FACILITY is an institution which has been licensed by the state of Michigan and certified by Medicaid to provide skilled care nursing services.

2.45 SPECIALIST is a physician to whom a Blue Cross Complete Member has been referred by the Blue Cross Complete primary care physician or his or her designee and/or Blue Cross Complete for special consultation or treatment.

3. Eligibility

3.01 MEMBERS – To be eligible to enroll, a person must:

- Be eligible for Medicaid as determined by MDHHS,
- Have a Medicaid status that is permitted by MDHHS to enroll in an HMO, and
- Reside within the service area.

3.02 In all cases, final determination of Blue Cross Complete eligibility is made by MDHHS.

4. Enrollment requirements

4.01 The categories of Medicaid-eligible persons who may enroll in HMOs are determined by MDHHS.

4.02 Newborns of Medicaid-eligible women are automatically enrolled in Blue Cross Complete effective with date of birth if the mother is a Blue Cross Complete Member at the time of delivery.

5. Disenrollment

5.01 If a Member wishes to disenroll, he/she must follow the procedures set forth by MDHHS. Disenrollment information is available upon request from the Customer Service department.

5.02 All rights to benefits stop on the effective date of disenrollment, without prejudice to claims for services rendered prior to the effective date of disenrollment. If the Member is a patient of an acute care facility at the time of disenrollment, Blue Cross Complete will cover the stay until the date of discharge. The disenrollment date is determined by MDHHS.

5.03 Blue Cross Complete may request special disenrollment of a Member from the Michigan

Department of Health and Human Services if a Member's actions are inconsistent with Blue Cross Complete membership. Disenrollment for an approved request will be effective immediately. Special disenrollment requests may be made in cases of:

- Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against Blue Cross Complete-affiliated providers, Blue Cross Complete staff or the public at Blue Cross Complete locations; or where stalking situations exist.

5.04 Special disenrollments will occur only to the extent consistent with the rules and regulations of MDHHS.

6. Effective date of coverage

6.01 All eligible, enrolled members will be covered under this Certificate on the date agreed upon between MDHHS and Blue Cross Complete.

7. Blue Cross Complete Member rights and responsibilities

7.01 RIGHTS AND RESPONSIBILITIES

Member rights will be honored by all Blue Cross Complete staff and affiliated providers.
Member rights:

- Understand information about your health care
- Get required care as described in this book
- Be treated with dignity and respect
- Privacy of your health care information, as outlined in this handbook
- Treatment choices, in spite of cost or benefit coverage
- Fully join in making decisions about your health care
- Refuse to accept treatment
- Voice complaints, grievance or appeals about Blue Cross Complete and its services, benefits, providers and care
- Get clear and easy to understand written information about Blue Cross Complete's services, practitioners, providers, rights and responsibilities policies
- Review your medical records and ask that they be corrected or amended
- Make suggestions regarding Blue Cross Complete's rights and responsibilities policies
- Be free from any form of abuse, being restrained or secluded, as a means of coercion, discipline, convenience or retaliation when receiving services
- Request and receive:
  - The Blue Cross Complete *Provider Directory*
  - The professional education of your providers, including those who are board certified in the specialty of pain medicine for evaluation and treatment
  - The names of hospitals where your physicians are able to treat you
  - The contact information for the state agency that oversees complaints or corrective actions against a provider
  - Any authorization, requirements, restrictions or exclusions by service, benefit or a specific drug
  - The information about the financial agreements between Blue Cross Complete and a participating provider

Member responsibilities:

- Know your Blue Cross Complete Certificate
- Know your *Member Handbook* and all other provided materials
- Call Customer Service with any questions
- Seek services for all nonemergency care through your primary care physician, except as otherwise stated in this Certificate
- Use the Blue Cross Complete network
- Be referred and approved by Blue Cross Complete and your primary care physician for out-of-network services
- Make and keep appointments with your primary care physician
- Contact your doctor's office if you need to cancel an appointment
- Be involved in decisions regarding your health
- Behave in a proper and considerate manner to providers, their staff, other patients and

Blue Cross Complete staff

- Tell Blue Cross Complete of address changes, any changes for your dependents coverage and any other health coverage
- Protect your card against misuse
- Call Customer Service right away if your card is lost or stolen
- Follow your doctor's instructions regarding your care
- Make treatment goals with your physician
- Contact Blue Cross Complete Special Investigations Unit if you suspect fraud

For more information, members may contact Customer Service.

7.02 PRIMARY CARE PHYSICIAN SELECTION AND CONTINUITY OF CARE

Upon enrollment, and by the effective date, the Member shall select a primary care physician for each member of the family. Blue Cross Complete reserves the right to choose a primary care physician for the Member if he/she does not indicate a physician selection. Blue Cross Complete will use prescribed guidelines to make such a selection.

Adult members may change their primary care physician or that of their enrolled child by submitting a request to Blue Cross Complete. Foster parents must contact the child's MDHHS case worker to change the child's primary care physician. Normally, a change will take effect days on the day Blue Cross Complete receives the request. Blue Cross Complete may limit the number of times a member can change PCPs without cause in a year.

If a member's PCP leaves the Blue Cross Complete network for any reason other than failure to meet Blue Cross Complete's quality standards or fraud, a Member who is undergoing an ongoing course of treatment with that physician may be eligible to receive treatment from that physician as follows:

- For as many as ninety (90) days after the Member receives notice that the contracted physician is leaving Blue Cross Complete's network.
- If the Member is in her second or third trimester of pregnancy at the time of her obstetrician's termination from the Blue Cross Complete network, she may continue with the terminated physician through post-partum care (i.e., the regular post-partum visit) directly related to that pregnancy.
- If the Member has been receiving care for a terminal illness, the member may continue to receive care from the treating physician for the terminal illness for the remainder of his or her life. All other care must be provided by contracted providers.

Continuity of care applies only if it is authorized by Blue Cross Complete unless stated otherwise in this Certificate. The departing physician must also agree to:

- Accept payment from Blue Cross Complete at the rates in place before the termination.
- Follow Blue Cross Complete's standards for maintaining quality health care.
- Provide Blue Cross Complete with medical information related to the care provided.
- Comply with Blue Cross Complete's policies and procedures, including those related to utilization review, referrals, prior authorization and treatment plans.

7.03 A Member enrolls in Blue Cross Complete knowing that providers are responsible for determining treatment. A Member may refuse procedures recommended by a doctor. If the refusal of a recommended procedure is due to lack of agreement between the doctor and patient and creates a barrier to care, the health plan may help the member change their doctor. If the Member refuses to accept recommended treatment or procedures and no alternatives exist, the Member shall be advised.

7.04 MEMBER APPEALS PROGRAM

Blue Cross Complete has set up a mechanism for receiving, processing, and resolving Member appeals and grievances relating to the benefits or the operation of Blue Cross Complete. This is fully described in the Blue Cross Complete Medicaid Plan *Member Handbook*, "Part 10: If you have a concern." Members will receive a copy of the *Member Handbook* describing the Member Appeals Program when they enroll with Blue Cross Complete, and may receive additional copies at any time by telephone request to Customer Service at the number listed below.

There is a time limit on filing an appeal. You must file within 90 days of the problem or denial. Contact us for a form to do this. If you have questions please call Customer Service at 1-800-228-8554 (TTY: 1-800-649-3777). You may also make an appointment to come into Blue Cross Complete's office.

7.05 MEMBER IDENTIFICATION CARDS

Having possession of the Blue Cross Complete Member Identification Card confers no right for benefits under this Certificate. To be entitled to benefits, the holder of the card must meet and maintain all MDHHS requirements.

If a member permits the use of his or her Member Identification Card by anyone else, the card may be reclaimed by Blue Cross Complete and/or its providers, and all rights of such Member and other members of his or her family can be terminated immediately (see Section 13.02). A Member shall report loss or theft of the Member Identification Card to Blue Cross Complete immediately upon discovery of loss or theft.

7.06 FORMS AND QUESTIONNAIRES

Members shall complete and submit to Blue Cross Complete such forms and medical questionnaires as requested. Members warrant that all information completed by them is true, correct, and complete to the best of their knowledge.

7.07 BENEFITS, POLICIES, AND PROCEDURES

The Member is responsible for becoming familiar with and following Blue Cross Complete Medicaid Plan benefits, policies, and procedures.

7.08 HEALTH MANAGEMENT PROGRAM

Enrolling in Blue Cross Complete entitles the Member to participate in Blue Cross Complete's Health Management Program which includes health promotion activities, health education activities, disease management programs, and case management programs.

7.09 MEMBERSHIP RECORDS

Blue Cross Complete will keep membership records. Blue Cross Complete is not liable for any obligation dependent upon information to be supplied by the Member prior to receipt in satisfactory form. Incorrect information furnished may be corrected if Blue Cross Complete has not acted to its prejudice by relying on it.

7.10 AUTHORIZATION TO RECEIVE INFORMATION

Member authorizes, subject to applicable confidentiality requirements, providers to disclose information about his or her care, treatment and physical condition to Blue Cross Complete. The member also permits Blue Cross Complete to copy his or her records.

8. Member's role in policy making

8.01 BOARD OF MANAGERS

As provided by law, at least one third of the Blue Cross Complete Board of Managers shall consist of adult enrollees elected by persons enrolled in Blue Cross Complete. Each Member will receive a list of Blue Cross Complete's Board of Managers with enrollee board members identified. Changes in Board membership shall be reflected in Blue Cross Complete's newsletter. Members may contact Blue Cross Complete or the representatives for information on becoming a member of the Board of Managers.

8.02 REGULAR COMMUNICATION

Members shall receive Blue Cross Complete's newsletter which will provide information regarding current policy, policy changes, and how best to take advantage of the Blue Cross Complete Plan services.

9. Payment for coverage

9.01 MDHHS is responsible for making premium payments to Blue Cross Complete for all Medicaid members. Payments shall be made in accordance with the terms of the agreement between Blue Cross Complete and MDHHS.

10. Claim provisions

10.01 It is not expected that a Member will make payments to any participating provider for benefits under this Certificate. However, if the Member provides evidence satisfactory to Blue Cross Complete that he/she has made payment to a contracted authorized provider in exchange for benefits, and that payment is the responsibility of Blue Cross Complete, the Member shall be reimbursed by Blue Cross Complete if an itemized bill and original evidence of payment (canceled check, cash receipt, etc.) is received by Blue Cross Complete no later than one year from the date of service. Receipts may be submitted to:

Blue Cross Complete
Attention: Claims
P.O. Box 7355
London, KY 40742

11. Coordination of benefits and subrogation

Other party liability

Blue Cross Complete does not pay claims or coordinate benefits for services which are not provided or authorized by a Blue Cross Complete physician and which are not benefits under this Certificate, except as otherwise stated in this Certificate.

11.01 GENERAL PROVISION

Blue Cross Complete will provide each of its Members with full benefits to the limit of this Certificate. However, a Member may not receive duplicate benefits, or benefits greater than the actual expenses incurred or Blue Cross Complete's fee schedule amount, whichever is less. Duplicate coverage does not extend Blue Cross Complete benefits beyond the limits of this Certificate.

The Member shall execute and deliver such instruments and take action as Blue Cross Complete may require to implement the provisions of this section. The Member shall do nothing to prejudice the rights given Blue Cross Complete by this provision without its prior written consent.

Benefits are not provided under this Certificate if any expenses to or on behalf of a member are paid or payable under the provisions of any other insurance, service benefit or reimbursement plan, including: Medicare, Worker's Compensation, Employer's Liability Law, or No Fault Automobile Insurance.

11.02 COORDINATION OF BENEFITS

If a Blue Cross Complete Member is injured in a car accident and needs care, Blue Cross Complete requires a statement noting the type of medical coverage carried on his automobile insurance.

Blue Cross Complete will follow the coordination of benefits guidelines of MDHHS.

All medical bills must first be submitted to the primary insurance carrier. Blue Cross Complete will generally be the payer of last resort.

11.03 SUBROGATION

If the Member has a right of recovery from person or organization for any benefits or supplies covered under this contract (except from a Member's health insurance coverage, subject to the coordination of benefits provisions), the Member, as a condition to receiving benefits under this contract, will either:

- Pay Blue Cross Complete all sums recovered by suit, settlement, or otherwise, to the extent of benefits provided by Blue Cross Complete and in an amount equal to the Blue Cross Complete payment for those benefits, but not in excess of monetary damages collected; or,
- Authorize Blue Cross Complete to be subrogated to the Member's rights of recovery, to the extent only of the benefits provided including the right to bring suit in the Member's name at the sole cost and expense of Blue Cross Complete.

In the event a suit instituted by Blue Cross Complete on behalf of the Member results in monetary damages awarded in excess of the cash value of actual benefits provided by Blue Cross Complete, Blue Cross Complete shall have the right to recover costs of suit and attorney fees out of the excess, to the extent of the cost of such fees.

11.04 RIGHT OF PAYMENT AND RECOVERY

If Blue Cross Complete has provided benefits under the contract but another plan should pay, Blue Cross Complete has the right to deny payment or seek the reasonable cash value of each service from the other plan.

11.05 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Under the terms of this section, Blue Cross Complete may need to release or get Member information which it deems to be necessary. A Member who claims benefits under the contract must provide Blue Cross Complete with that information. This includes notifying Blue Cross Complete of any change in other insurance coverage.

12. Out-of-area coverage

12.01 Members are entitled to out-of-area coverage for urgent and emergent medical care.

Routine out-of-area care must be requested in advance by the primary care physician and approved in writing in advance by Blue Cross Complete. Services approved by Blue Cross Complete to be received outside the state of Michigan will be administered consistent with the requirements of MDHHS and through BlueCard, a Blue Cross Blue Shield Association Program. Health care services provided outside the country are not covered by Blue Cross Complete. For more information, please call Customer Service.

13. Term and termination

13.01 TERM

This Certificate shall continue in effect from the effective date as long as the Member is eligible according to MDHHS and as long as Blue Cross Complete is contracted with the state of Michigan as a qualified health plan for the Medicaid program.

13.02 TERMINATION FOR CAUSE

Coverage for a Member may be terminated for cause, subject to reasonable notice and the consent of MDHHS for:

- Violent/Life-Threatening situations including physical acts of violence; physical or verbal threats of violence made against Blue Cross Complete-affiliated providers, Blue Cross Complete staff, or the public at Blue Cross Complete locations; or where stalking situations exist.

NOTE: On or after the effective date of termination for cause, premium payments received on behalf of such terminated Member for periods following the termination date shall be refunded to MDHHS. Blue Cross Complete shall however, make reasonable attempts to transfer care of patients terminated from the Plan to other providers.

13.03 LOSS OF ELIGIBILITY

Blue Cross Complete will request disenrollment of Member from MDHHS if the Member is no longer eligible for coverage under the contract as specified in Section 3, Eligibility.

13.04 CESSATION OF OPERATIONS

In the event of cessation of operations or dissolution of Blue Cross Complete, this Certificate may be terminated immediately by order of proper authority. Blue Cross Complete may be obligated for services as prescribed by law or proper order.

14. Benefits

14.01 Members can get the services described under the terms and conditions of this Certificate. Blue Cross Complete primary care physicians need to provide care to Blue Cross Complete Members, except as noted.

When needed, the Member's PCP will refer the member to a specialist. Usually, the specialist will participate with Blue Cross Complete. Blue Cross Complete has no liability or obligation for any benefits received by Members from other doctors, hospitals or entity unless requested in advance by the doctor or prior approved by Blue Cross Complete.

Certain exceptions apply (e.g., emergency services, routine obstetrical and gynecological services). If you have not chosen a Blue Cross Complete pediatrician to be your child's PCP and want to take your child to a Blue Cross Complete pediatrician, you can do so without a referral. Blue Cross Complete may assign that doctor to be your child's PCP.

You don't pay for services covered by Blue Cross Complete, when they are medically necessary and arranged by your PCP. The following is a list of those services, which are also listed in the Handbook:

- Blood lead testing for members under age 21
- Breast cancer services – services to treat breast cancer as required by federal and state women's health and cancer protection acts. These include diagnostic, outpatient treatment and rehabilitative services.
- Breast pumps; personal use, double-electric
- Chiropractic services
- Diagnostic laboratory, X-ray and other imaging services
- Doctor office visits
- Emergent and urgent care services
- Family-planning services
- Health education – disease management programs
- Hearing examinations for all members and hearing aids for members under age 21
- Home health services and skilled nursing home services when medically necessary. (You can use these after you leave the hospital or instead of going to the hospital. Your primary care physician will help you arrange these services.)
- Hospice services (if you request)
- Hospital services requiring an overnight stay, including:
  - Cost of a semi-private room (sharing a room with one other person)
  - Doctor services
  - Surgical services
  - Anesthesia (medication to relax or put you to sleep before surgery)
  - X-rays
  - Laboratory services
- Long-term acute care hospital services
- Maternal Infant Health Program - for pregnant women and infants who are enrolled in a health plan. The program offers free rides to medical visits and childbirth or parenting classes. During scheduled home visits, a health professional will help with health matters that can affect pregnancy, including:
  - Asthma
  - Depression and anxiety
  - High blood pressure
  - High blood sugar
  - Smoking
  - Alcohol or drug use
  - Getting health care while the member is pregnant (prenatal care)
  - Finding food or a place to live
  - Concerns about abuse or violence

- Medical equipment and supplies, durable
- Mental health services – short term, up to 20 outpatient visits per year
- Midwife services – when provided by a certified nurse midwife in a health care setting
- Nurse practitioner services – when provided by a certified pediatric or family nurse
- Out-of-network services – when authorized by Blue Cross Complete, except as otherwise stated in this Certificate
- Parenting and birthing classes
- Physical exams – routine or annual physical exams
- Podiatric (foot specialist) services, when medically necessary
- Practitioner services – such as those provided by physicians and specialists
- Pregnancy care – including prenatal and postpartum care (before and after birth)
- Prescriptions and pharmacy services
- Prosthetics and orthotics
- Rehabilitative or restorative services – intermittent or short term, in a nursing facility for up to 45 days
- Rehabilitative or restorative services in a place of service other than a nursing facility
- Renal disease services – end stage
- Restorative or rehabilitative services in a health care location other than a nursing facility.
- Sexually transmitted disease treatment
- Smoking and tobacco cessation treatment, including drugs and behavioral support (tobacco quit program)
- Specialist visits
- Surgical services – not requiring an overnight hospital stay
- Therapy – physical, speech and language, occupational
- Transplant services
- Transportation – by ambulance and other emergency medical transport
- Transportation – to nonemergency covered medical services
- Vaccinations (covered vaccinations do not require prior authorization if provided by local health departments.)
- Vision – routine services
- Weight-reduction services – if medically necessary
- Well-baby and well-child care – Early Periodic Screening Diagnosis and Treatment Program for persons under age 21

Healthy Michigan Plan enrollees

The covered services provided to Healthy Michigan Plan enrollees under this contract include all those listed above and the following services:

- Habilitiative services
- Dental services
- Hearing aids for persons age 21 and older

Your primary care physician can help you get the Blue Cross Complete services you need. Customer Service can also answer questions about your benefits.

Blue Cross complete of Michigan

Blue Cross Complete of Michigan LLC is an independent licensee of the Blue Cross and Blue Shield Association.

Nondiscrimination Notice and Language Services

Discrimination is against the law

Blue Cross Complete of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross Complete of Michigan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross Complete of Michigan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (large print, audio, accessible electronic formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross Complete of Michigan 24 hours a day, 7 days a week, at **1-800-228-8554.** TTY users can call **1-888-987-5832.**

If you believe that Blue Cross Complete of Michigan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

- **Blue Cross Complete of Michigan Member Grievances**
  P.O. Box 41789, North Charleston, SC 29423
  1-800-228-8554 (TDD/TTY **1-888-987-5832**)
- If you need help filing a grievance, Blue Cross Complete of Michigan Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, **800-537-7697** (TDD)

Complaint forms are available at: **hhs.gov/ocr/office/file/index.html**.

COM-11Rev101116
BCC.DISC002.20171127

Multi-language interpreter services

English: ATTENTION: If you speak English, language assistance services, at no cost, are available to you. Call **1-800-228-8554** (TTY: **1-888-987-5832**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-228-8554** (TTY: **1-888-987-5832**).

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم **1-800-228-8554** (TTY: **1-888-987-5832**).

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。请致电：**1-800-228-8554** (TTY: **1-888-987-5832**)。

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電 **1-800-228-8554** (TTY: **1-888-987-5832**)。

Syriac:
ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ
ܕܡܩܒܠܝܬܘܢ ܚܠܦ ܡܫܡܫܢܘܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
(TTY **1-888-987-5832**) **1-800-228-8554**

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-228-8554** (TTY: **1-888-987-5832**).

Albanian: VINI RE: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-228-8554** (TTY: **1-888-987-5832**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-228-8554** (TTY: **1-888-987-5832**) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলায় কথা বলেন, তাহলে নিঃখরচায় ভাষা সহায়তা পেতে পারেন। **1-800-228-8554** (TTY: **1-888-987-5832**) নম্বরে ফোন করুন।

Polish: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-228-8554** (TTY: **1-888-987-5832**).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-228-8554** (TTY: **1-888-987-5832**).

Italian: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-228-8554** (TTY: **1-888-987-5832**).

Japanese: 注意事項：日本語を話される場合、無料の通訳サービスをご利用いただけます。**1-800-228-8554** (TTY: **1-888-987-5832**) まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-228-8554** (TTY: **1-888-987-5832**).

Serbo-Croatian: PAŽNJA: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-228-8554** (TTY: **1-888-987-5832**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-228-8554** (TTY: **1-888-987-5832**).

Find us online at

MiBlueCrossComplete.com

R077322