

# MEMBER CERTIFICATE BCN 1

## SCHEDULE OF BENEFITS

### PLEASE NOTE:

This Schedule of Benefits is only part of the Certificate. Please refer to it in conjunction with the Health Plan booklet entitled General Provisions. This Schedule of Benefits and any riders are incorporated with and become part of the Certificate issued by Health Plan.

### ***I. SCHEDULE OF BENEFITS***

#### ***1.01 GENERAL RESTRICTIONS***

This Health Plan is a health maintenance organization which operates on a direct service rather than indemnity basis.

Except for emergency care under Section 1.05, coverage under this Certificate for services and benefits listed below is available only when provided, authorized, or approved by Health Plan. Except as expressly provided in this Article, only services which are medically necessary according to generally accepted standards of practice are benefits under this Certificate. The services and benefits listed below are subject to the limitations and exclusions set forth in Article II of this Schedule of Benefits.

#### ***1.02 PROFESSIONAL SERVICES***

- A. Office Visits for diagnosis or treatment of disease, condition, or injury provided by Plan Physician or by a Referral Physician.
- B. Maternity Care, including pre- and postnatal visits to a Plan Physician, delivery, and related obstetrical services.
- C. Pediatric Care for well-child and for diagnosis and treatment of illness or injury. Well-child care means a clinical check of a child up to age 6 in the absence of symptoms for the purpose of assessing physical status and detecting abnormalities. The frequency of well-child visits is determined by the Plan Physician.
- D. Inpatient Professional Services of Plan and Referral Physicians including anesthesiologists, pathologists, radiologists, and other medical specialties as deemed necessary for the care and treatment of the Member by the Plan Physician.
- E. Consultations deemed medically appropriate by Plan Physician.
- F. Surgery when determined to be medically necessary.
- G. Allergy Care as deemed medically necessary including evaluation, testing, and serum.

### **1.03 INPATIENT HOSPITAL SERVICES**

- A. Semi-private room and board, general nursing services, special diets if medically necessary. Private room only when authorized as medically necessary.
- 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 functional occupational therapy when authorized by the Plan Physician.
- F. Oxygen and gas therapy, drugs and biological solutions, dressings and materials used in casts, radioisotopes and radium, blood and blood products, skin, bone and tissue bank expenses.
- G. Maternity care and routine nursery care of newborn.
- H. Other inpatient services and supplies medically necessary for admission, diagnosis, and treatment of the Member.

### **1.04 OUTPATIENT HOSPITAL SERVICES**

Outpatient services, including chemotherapy, delivered in a hospital or other facility approved by Health Plan are a benefit when authorized by the Plan Physician.

### **1.05 EMERGENCY CARE**

- A. In case of an immediate and unforeseen medical emergency you should seek treatment immediately. It is suggested, but not required, that you, the hospital, or someone acting for you, notify your Primary Care Physician or BCN within 24 hours or as soon as medically reasonable. Coverage is provided for medically necessary emergency services when they are needed immediately because of an accidental injury or sudden illness, and the time required to contact your Primary Care Physician could result in permanent damage to your health. All benefits under this Certificate must be provided or authorized by your Primary Care Physician or BCN, except in the case of an immediate and unforeseen medical emergency.
  - 1. Accidental injury means a traumatic bodily injury which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.
  - 2. Medical Emergency means a sudden and immediate medical condition which could be expected to result in permanent damage to your health if not treated immediately.

- B. Emergency services include medically necessary professional services, urgent care center services, hospital emergency room and related ancillary services.
- C. All follow-up care to initial emergency treatment, such as removal of stitches and dressings, is covered only when provided or approved by BCN or by your Primary Care Physician.
- D. If a Member is hospitalized for emergency care in a non-affiliated hospital or outside of the BCN service area, BCN may require that the Member be transferred to an affiliated hospital or other facility within the service area as soon as medically feasible.
- E. When emergency care is obtained without being prearranged or authorized, the care will be covered only if the Member's signs and symptoms at the time of treatment, verified by the treating physician, confirm the existence of a Medical Emergency or an Accidental Injury.

## 1.06 **AMBULANCE**

As used in this Certificate, ambulance means a ground vehicle specially equipped and licensed for transporting injured or sick persons.

- A. **Nonemergency** ground ambulance services are a benefit only when medically necessary and preauthorized by a Plan Physician or when ordered by an employer, school, or public safety official and the Member is not in a position to refuse.
- B. **Emergency** ambulance services, including ground and air ambulance services are a benefit when one or several of the following situations occurs:
  - You are admitted as an inpatient to the hospital immediately following emergency room treatment.
  - The services are necessary for management of shock, unconsciousness, 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.

In any situation the following conditions must also be met:

  - You must be transported to the nearest hospital capable of treating your condition.
  - The service must be provided by a licensed ambulance service.
- C. **Air ambulance** for emergency transport is covered to the nearest hospital equipped to treat your condition until the point of stabilization. Once the member's condition is stabilized, air ambulance is not a benefit. See section 1.05 for the definition of emergency care.

### **1.07 DIAGNOSTIC AND THERAPEUTIC SERVICES AND TESTS**

Therapeutic and diagnostic laboratory, pathology and radiology services and other procedures which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition are covered when authorized by a Plan Physician.

### **1.08 PREVENTIVE AND EARLY DETECTION SERVICES**

In addition to services listed elsewhere in this Article, Health Plan provides the following preventive and early detection health services:

- A. Periodic physical examinations and health assessments prescribed by a Plan Physician at intervals deemed appropriate in relation to the age, sex and medical history of the Member.
- B. Pediatric and adult immunizations in accordance with accepted medical practice.
- C. Vision and hearing examinations for children through the age of 17 and vision and hearing screening for adults to determine the need for vision or hearing examination.
- D. Nutrition and health education and counseling when prescribed by a Plan Physician.

### **1.09 REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES**

- A. History, physical examination, laboratory tests, advice, counseling, and medical supervision related to family planning, sex education, and prevention, and prevention of venereal disease in accordance with generally accepted medical practice.
- B. Medically indicated genetic testing and counseling in accordance with generally accepted medical practice.
- C. Except as provided in Section 2.12, services for diagnosis, counseling, and treatment of infertility are covered in accordance with generally accepted medical practice. Following the initial sequence of diagnostic work-up and treatment additional work-ups and treatment will be undertaken only when determined by BCN to be in accordance with generally accepted medical practice.
- D. Adult sterilization procedures.
- E. Elective termination in accordance with locally accepted medical practice.

### **1.10 SKILLED NURSING FACILITY**

A Member is entitled to a maximum of 730 days of skilled nursing care in a Skilled Nursing Facility when such care is authorized by a Plan Physician as medically necessary for convalescence from surgery, disease, or injury. This benefit does not cover custodial, basic or domiciliary care.

### **1.11 HOME CARE SERVICES**

Home care is a benefit when authorized as medically necessary by a Plan Physician. Home Care ordinarily includes intermittent skilled nursing care and may include other health care services specifically ordered by the Plan Physician. Home Care does not include housekeeping services and is not a benefit for the purpose of providing long-term custodial maintenance.

### **1.12 MENTAL HEALTH**

Except for emergency care under Section 1.05, the mental health services listed below are benefits only when provided or preauthorized by Health Plan. Subject to the limitations and exclusions in Sections 2.10 and 2.11, the following services are covered:

- A. Outpatient evaluation, crisis intervention, and short-term therapy when prescribed, provided or authorized by a Health Plan provider for conditions which, according to generally accepted medical standards, are deemed amenable to favorable modification. Services for chronic conditions which are not amenable to favorable modification are not covered except for crisis intervention and short-term treatment for acute episodes. This benefit is limited to a maximum of 20 visits per Member per calendar year.
- B. Inpatient mental health treatment when authorized by a Health Plan provider in an approved facility for conditions which, according to generally accepted medical standards, are deemed amenable to favorable modification. Inpatient treatment for chronic conditions which are not amenable to favorable modification are not covered except for crisis intervention and short-term treatment for acute episodes. This benefit is limited to 45 days renewable 60 days after discharge from a mental health inpatient facility or partial hospitalization program.
- C. To the extent that coverage remains available under Paragraph B above, mental health treatment in a partial hospitalization (day or night care) program which has been approved by Health Plan is covered when prescribed or authorized by the Health Plan provider. The inpatient mental health benefit is reduced one day for every two days in a partial hospitalization program.

### **1.13 SUBSTANCE ABUSE**

#### **A. Definitions:**

- 1. "Outpatient Substance Abuse Treatment" means services provided on an ambulatory basis to persons who are physiologically or psychologically dependent upon or abusing alcohol or drugs, which services may include some or all of the following: chemotherapy, counseling, detoxification, medical testing, diagnostic evaluation and referral to other services.

2. "Intermediate Substance Abuse Treatment" means service provided in a full 24-hour residential or hospital setting or in a partial, less than 24-hour, residential or hospital setting to persons physiologically or psychologically dependent upon or abusing alcohol or drugs, which services may include some or all of the following: chemotherapy, counseling, detoxification, medical testing, diagnostic evaluation and referral to other services.
  3. "Detoxification" means the medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs. Detoxification can occur in an inpatient, outpatient, or residential setting.
- B. Except for emergency care under Section 1.05, the substance abuse treatment services listed below are benefits only when provided or preauthorized by Health Plan. Subject to the limitations and exclusions in Section 2.11, the following services are covered:
1. Detoxification is covered for acute conditions on an inpatient basis and for acute and non-acute conditions in an outpatient or intermediate setting.
  2. Outpatient Substance Abuse Treatment is a benefit when provided or preauthorized by Health Plan. This benefit is limited to a maximum of 35 visits per calendar year.
  3. Intermediate Substance Abuse Treatment is a benefit when prescribed or preauthorized by a Health Plan provider when the provider makes a determination of substance abuse, certifies a treatment plan, level of care, and length of stay. Intermediate care is covered only in a Health Plan approved facility.
  4. Intermediate Substance Abuse Treatment is limited to 45 days renewable after a lapse of at least 60 consecutive days between the date of last discharge from a hospital, residential center, partial residential program, or another residential substance abuse treatment facility whether or not benefits were provided for the last admission. Intermediate is subject to the 45 day inpatient mental health maximum.
  5. To the extent that coverage remains available under subparagraph 3 above, treatment in a partial residential program (day or night care) which has been approved by Health Plan is covered when prescribed or authorized by a Health Plan provider. The intermediate substance abuse treatment benefit is reduced by one half day for each day or night in a partial residential program.

#### **1.14 PHYSICAL THERAPY AND REHABILITATION SERVICES**

We cover medically necessary short-term outpatient physical therapy and medical rehabilitation services, including speech therapy, when authorized by the health plan. This benefit is limited to 60 visits per medical episode per plan year. Covered in full.

### **1.15 DURABLE MEDICAL EQUIPMENT**

Durable medical equipment means equipment which is primarily and customarily used for medical purposes, which is intended for repeated use and which is not generally useful to a person in the absence of illness or injury. Benefits for the rental or purchase of durable medical equipment are limited to the basic equipment plus medically necessary special features prescribed by the Plan Physician. In addition:

- A. The equipment must be an item of durable medical equipment as defined by Health Plan and must be appropriate for use in the home.
- B. The equipment must be obtained from Health Plan or from an approved supplier.
- C. The equipment must be prescribed or authorized by the Member's Plan Physician.
- D. The equipment, whether purchased, rented, or capitated, remains the property of the Health Plan or its agent and must be returned when no longer medically needed by the Member.
- E. Equipment for which benefits are not payable includes, but is not limited to:
  - 1. Deluxe equipment such as motor-driven wheelchairs and beds, unless medically necessary for the treatment of the patient's condition and required in order for the patient to operate the equipment himself; and
  - 2. Items not medical in nature.
  - 3. Comfort and convenience items such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, and air conditioners.
  - 4. Physician's equipment such as sphygmomanometers and stethoscopes.
  - 5. Disposable supplies such as disposable sheets and elastic stockings.
  - 6. Exercise and hygienic equipment such as exercycles, Moore wheels, bidet toilet seats, and bathtub seats.
  - 7. Self-help devices not primarily medical in nature such as sauna baths, elevators and ramps, special telephone or communication devices, corrective shoes and arch supports.
  - 8. Experimental or research equipment.

### **1.16 PROSTHETICS, ORTHOTICS AND CORRECTIVE APPLIANCES**

- A. Prosthetic devices means devices which aid body functioning or replace a limb or body part after accidental or surgical loss and orthotic appliances means appliances which are used to correct a defect of body form or function. Benefits are provided only for the basic prosthetic or orthotic appliance and any medically necessary special features prescribed by the Plan Physician. In addition:

1. The item must be a prosthetic or orthotic device or appliance as defined by Health Plan.
  2. The items must be obtained from Health Plan or from an approved supplier.
  3. The item must be prescribed or authorized by the Plan Physician.
  4. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered.
- B. Corrective appliances and artificial aids such as cardiac pacemakers and artificial heart valves are a covered benefit when authorized as medically necessary by the Plan Physician. Benefits are provided for the initial prescription lenses (eyeglasses or contact lenses) following an operation for cataract or other diseases of the eye or to replace an organic lens used during convalescence from authorized eye surgery. In the case of cataract surgery, congenital absence, or aniseikonia, following the initial lenses additional prescription lenses are covered if medically necessary. Appliances must be obtained through the Health Plan or from a supplier approved by the Health Plan.
- C. Ostomy sets and accessories; catheterization equipment and urinary sets are covered.
- D. Burn Pressure Garments are covered when prescribed by the Member's Plan Physician to enhance healing, reduce swelling and control scarring in case of severe burns. Burn pressure garments must be obtained from a Health Plan approved supplier.
- E. Pressure Gradient Supports are covered when prescribed by the Member's Plan Physician as medically necessary for severe circulatory conditions, high risk pregnancy, and post surgical care. Pressure gradient supports must be obtained from a Health Plan approved supplier. Benefits are available for no more than four supports per calendar year, except additional supports may be covered if the member's Plan Physician determines that they are necessary because of a significant weight gain or loss.
- F. Benefits are not available for:
1. Dental appliances, hearing aids, eyeglasses or contact lenses, (except as provided in a rider or in Section B above), or for nonrigid appliances and supplies including but not limited to garter belts, arch supports, corsets, corrective shoes, and wigs or hair pieces.
  2. Experimental or research devices or appliances.

### **1.17 ORGAN AND TISSUE TRANSPLANTS**

Transplant of an organ or body tissue at a BCN approved facility is a benefit when the transplant procedure is considered non-experimental in accordance with generally accepted medical practice, the procedure is medically necessary and it is authorized by BCN. Non-experimental transplants include kidney transplants, corneal transplants and liver transplants for children with biliary atresia and other rare congenital abnormalities. BCN will cover the necessary hospital, surgical, laboratory and x-ray expenses incurred by a non-Member donor for an authorized transplant to a Member unless the non-Member has coverage for such expenses.

### **1.18 RECONSTRUCTIVE AND COSMETIC SURGERY**

Elective cosmetic surgery is a benefit only when authorized by a Plan Physician for correction of conditions resulting from accidental injury or traumatic scars; for repair of a surgical injury or deformities; for correction of a congenital anomaly of a child; or for correction of deformities resulting from disease such as Bell's Palsy or fibrocystic disease. Therapeutic reconstructive surgery is a benefit when authorized by a Plan Physician as medically necessary.

### **1.19 ORAL SURGERY**

Oral surgery and x-rays are a benefit only when authorized by a Plan Physician for the following conditions:

- A. Treatment of fractures of the jaw and facial bones, and dislocation of the jaw.
- B. Oral surgery necessary for prompt repair of trauma of the jaw, natural teeth, cheeks, lips, tongue, and roof and floor of the mouth.
- C. Medically necessary cutting procedures for treatment of lesions, tumors and cysts on or in the mouth, as prescribed by a Plan Physician.
- D. Hospital services and related medical services for oral surgical procedures which are medically required to be performed on an inpatient or outpatient hospital basis because of an unrelated medical condition.

## **II. EXCLUSIONS AND LIMITATIONS**

### **2.01 UNAUTHORIZED AND OUT-OF-PLAN SERVICES**

The Health Plan is not an insurance company but a health maintenance organization which operates on a direct service basis. Health, medical, hospital, and other services obtained by a Member outside of the Health Plan and not pre-authorized by a Plan Physician are not a covered benefit under this Certificate and cannot be reimbursed to the Member or paid for by the Health Plan. This exclusion does not apply to emergency care as specified in Section 1.05 of this Schedule of Benefits.

### **2.02 SERVICES WHICH ARE NOT MEDICALLY NECESSARY**

Except as expressly provided in the Certificate, services which are not medically necessary are not covered. The final determination of medical necessity is the judgement of the Plan Physician with the concurrence of the Plan Medical Director.

### **2.03 NONCOVERED SERVICES**

Office visits, examinations, treatments, tests, and reports relating to requirements or documentation of health or medical status for employment, insurance, travel, or for legal proceedings are not a benefit.

### **2.04 COSMETIC SURGERY**

Cosmetic surgery is not a benefit except as specifically provided in Section 1.18.

### **2.05 PRESCRIPTION DRUGS**

Prescription drugs, devices, and medicines incidental to outpatient care are not covered under this Certificate. Refer to Rider.

### **2.06 MILITARY CARE**

Care for military service connected disabilities for which the Member is legally entitled to services and for which facilities are reasonably available are not covered.

### **2.07 CUSTODIAL CARE**

Custodial or domiciliary care in a nursing home, residential institution or other setting which is not incidental to support medical and skilled nursing care but is primarily for the purpose of maintaining the Member's basic needs for food, shelter, and clothing is not a benefit.

## **2.08 COMFORT ITEMS**

Personal or comfort items such as telephone, television, and similar items are excluded.

## **2.09 RESEARCH OR EXPERIMENTAL SERVICES**

Benefits are not provided for care, services, supplies, devices, drugs, or procedures which are experimental, or research in nature unless specifically approved as a benefit by the Health Plan Board of Directors. Unusual procedures or services for which costs or risks are excessive and probable benefits are slight are not benefits except as determined by the Health Plan's Medical Director.

## **2.10 CHRONIC MENTAL CONDITIONS**

Treatment for chronic mental conditions which are not amenable to favorable modification is excluded except as provided in Section 1.12.

## **2.11 COURT RELATED SERVICES**

Pretrial or court testimony and the preparation of court related reports are not a benefit. Court ordered treatment for substance abuse or mental condition is not a benefit except to the extent covered under, provided, and authorized in accordance with Sections 1.12 and 1.13.

## **2.12 SPECIAL ELECTIVE PROCEDURES**

Reversal of surgical sterilization, in vitro fertilization procedures (GIFT and ZIFT), artificial insemination (except for treatment of infertility) and all services related to surrogate parenting arrangements, including but not limited to maternity and obstetrical care for non-Member surrogate parents, are not covered under this Certificate. Transsexual surgery and preparatory treatment thereto are not covered. Radial keratotomy is not covered.

## **2.13 DENTAL SERVICES**

Dental services, dental prosthesis, x-rays, and oral surgery are not a benefit under this Certificate except as specifically provided in Section 1.19.

## **2.14 SERVICES COVERED THROUGH OTHER PROGRAMS**

Benefits do not include any services to the extent benefits are available, provided, paid, or payable:

- A. Under an extended benefits provision of any other health insurance or health benefits plan, group policy, group program, or group certificate.
- B. Under any public health care, school, or public program supported in whole or in part by state, federal or local government funds except where Health Plan is made primary by law.

## **2.15 GASTROINTESTINAL PROCEDURES**

Benefits do not include coverage for gastrointestinal bypass, gastric stapling, or other surgery for weight reduction unless authorized by a Plan Physician as medically necessary, rendered in connection with an unrelated medical condition and considered to be nonexperimental and in accordance with generally accepted medical practice.