Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Michigan Conference - United Methodist
AOXAR3
Community Blue PPO^{SM} ASC
Effective Date: On or after January 2019
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $25 copay for office visits and office consultations with a **primary care physician** • $40 copay for office visits and office consultations with a **specialist** • $25 copay for medical online visits • $25 copay for chiropractic and osteopathic manipulative therapy • $200 copay for emergency room visits • $50 copay for urgent care visits	• $200 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance use disorder treatment • 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 30% of approved amount for mental health care and substance use disorder treatment • 30% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$3,250 for one member, $6,500 for the family (when two or more members are covered under your contract) each calendar year	$6,500 for one member, $13,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	70% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	

Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	70% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	• $25 copay for each office visit with a **primary care physician** • $40 copay for each office visit with a **specialist**	70% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$25 copay per online visit	70% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	70% after out-of-network deductible
Office consultations - must be medically necessary	• $25 copay for each office consultation with a **primary care physician** • $40 copay for each office consultation with a **specialist**	70% after out-of-network deductible
Urgent care visits - must be medically necessary	$50 copay per urgent care visit	70% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$200 copay per visit (copay waived if admitted or for an accidental injury)	$200 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after in-network deductible	90% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible

Benefits	In-network	Out-of-network
Postnatal care visit	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible	70% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after in-network deductible Unlimited days	70% after out-of-network deductible
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	90% after in-network deductible Limited to a maximum of 120 days per member per calendar year	90% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	90% after in-network deductible	90% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	90% after in-network deductible	90% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	90% after in-network deductible	70% after out-of-network deductible

Benefits	In-network	Out-of-network
Voluntary abortions	90% after in-network deductible	70% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	90% after in-network deductible	70% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	90% after in-network deductible	90% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$25 copay per online visit	70% after out-of-network deductible
• Physician's office	90% after in-network deductible	70% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 90% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$25 copay per visit	70% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	70% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

Medtipster® Rx Prescription Drug Coverage

Summary of Benefits and Coverage for:
Michigan Conference of the United Methodist Church

This is intended as an easy-to-read summary and provides only a general overview of your benefits. Additional limitations and exclusions may apply. Payment amounts are based on approved amounts, less any applicable deductible and/or copay. For a complete description of benefits, please see your summary plan document. If there is a discrepancy between this summary of benefits and coverage and your applicable plan document, the plan document will control.

Generic prescription drugs	*$15 for each drug*
Preferred Brand name prescription drugs	*$30 for each drug*
Non-Preferred Brand name prescription drugs	*$60 for each drug*
Specialty prescription drugs (30 day supply only)	*25% for each drug*
Mail order (home delivery) prescription drugs	**Copay for a 31 to 90 day supply:** • *$30 for each generic drug* • *$60 for each preferred brand name drug* • *$120 for each non-preferred brand name drug*
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** *Needles and syringes have no copay.*	*Covered – 100% less plan copay for the insulin or other covered injectable legend drug*

Note: *If you request the brand-name drug when a generic equivalent is available on the MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic* **plus** *the applicable copay.*

Covered services

Prescribed generic contraceptives	*Covered – 100%*
Prescribed over-the-counter (OTC) drugs – when covered by Medtipster.	*Covered – 100% less plan copay*
Prescribed qualifying Medtipster generic drugs filled at a preferred Medtipster network pharmacy – when covered by Medtipster. Qualifying generic and preferred pharmacy information is available at www.medtipsterfree.com.	*Covered – 100%*
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** *Needles and syringes have no copay.*	*Covered – 100% less plan copay for the insulin or other covered injectable legend drug*

Note: *Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.*

Features of your plan

Drug interchange	*Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified, unless the prescribing physician demonstrates that the drug is medically necessary.* *If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay.*
Quantity limits	*Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization.*
Annual out-of-pocket maximum	*$4,000.00 per individual, $8,000.00 per family.*