Blue Cross Blue Shield of Michigan

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

Michigan Conference - United Methodist
CAOXAR3
Supplemental Care Coverage
Effective Date: On or after January 2019
Benefits-at-a-glance

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit you local Social Security office or consult the Medicare handbook (available on the Medicare Web site at **medicare.gov** or at any Social Security office)

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

Note: Medicare deductible and coinsurance amounts are effective January 1, 2018 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	• **Medicare Part A** $1,340 (for days 1-60) each benefit period • **Medicare Part B** $183 per calendar year	None
Coinsurance/fixed dollar copays	• **Hospital stay** $335 per day (for days 61-90) and $670 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • **Skilled nursing facility stay** (a limit of 100 days each benefit period) $167.50 per day (for days 21-100)	None
Coinsurance/percent copay amounts	• 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care	None

Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months **Note:** Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered **Note:** Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50 **Note:** A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount • 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
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - **does not** include private duty nursing • Days 1-60 of each benefit period	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
• Days 61-90 of each benefit period	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria • Days 1-20 of each benefit period	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 21-100 of each benefit period	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a **Medicare-certified** home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Human organ transplants

Note: Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pancreas transplants	Not covered **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note:** Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Inpatient mental health care in psychiatric facility • Days 1-190 **lifetime**	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) **Note:** In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible **Note:** If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible **Note:** You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible **Note:** There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

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.*