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

BERRIEN COUNTY

007015910/0006
M - FOP LABOR COUNCIL CIVILIAN
Comprehensive Major Medical (CMM) ASC
Effective Date: On or after January 2017
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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. 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 disease 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 and dollar maximums)

Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	Coverage
Deductibles	$250 for one member, $500 for a family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 10% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance abuse treatment • 10% of approved amount for most other covered services
Annual out-of-pocket maximums-applies to copays for all covered services - including mental health and substance abuse services - but does not apply to fixed dollar copays and private duty nursing percent copays	$1,250 for one member, $2,500 for a family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	None

Preventive care services

Benefits	Coverage
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.
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.
Pap smear screening-laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)
Contraceptive injections	100% (no deductible or copay/coinsurance)
Well-baby and child care visits • 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	100% (no deductible or copay/coinsurance)
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)
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year

Benefits	Coverage
Routine mammogram and related reading	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.
Colonoscopy-routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy,one per member per calendar year **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.

Physician office services

Benefits	Coverage
Office visits	90% after deductible
Online visits	90% after deductible
Outpatient and home medical care visits	90% after deductible
Office consultations	90% after deductible

Emergency medical care

Benefits	Coverage
Hospital emergency room	90% after deductible
Ambulance services-must be medically necessary	90% after deductible

Diagnostic services

Benefits	Coverage
Laboratory and pathology services	90% after deductible
Diagnostic tests and x-rays	90% after deductible
Therapeutic radiology	90% after deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	Coverage
Prenatal care visits	100% (no deductible or copay/coinsurance)
Postnatal care	90% after deductible
Delivery and nursery care	90% after deductible

Hospital care

Benefits	Coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after deductible, unlimited days
Inpatient consultations	90% after deductible
Chemotherapy	90% after deductible

Alternatives to hospital care

Benefits	Coverage
Skilled nursing care-must be in a **participating** skilled nursing facility	90% after 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)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	90% after deductible, limited to a maximum 100-visits per member per calendar year
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 deductible

Surgical services

Benefits	Coverage
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after deductible
Presurgical consultations	• 100% (no deductible or copay/coinsurance) when obtained from a **participating** provider • 90% after deductible when obtained from a **nonparticipating** provider
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	90% after deductible
Voluntary Abortions	90% after deductible
Removal of impacted and partial bony impacted teeth - includes surgery and related anesthesia	90% after deductible

Human organ transplants

Benefits	Coverage
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)
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after deductible
Kidney, cornea and skin transplants	90% after deductible

Mental health care and substance abuse treatment

Benefits	Coverage
Inpatient mental health care and **inpatient** substance abuse treatment	90% after deductible, unlimited days

Benefits	Coverage
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 deductible
Outpatient mental health care	90% after deductible
Outpatient substance abuse treatment-in approved facilities **only**	90% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	Coverage
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.	90% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after deductible
Other covered services, including mental health services, for autism spectrum disorder	90% after deductible

Other covered services

Benefits	Coverage
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no cost-sharing when rendered by a participating provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 90% after deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training
Allergy testing and therapy	90% after deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	90% after deductible, limited to a **combined** 38-visit maximum per member per calendar year
Outpatient physical, speech and occupational therapy- provided for rehabilitation	90% after deductible,, unlimited treatment
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 deductible
Prosthetic and orthotic appliances	90% after deductible
Private duty nursing	90% after deductible
Hair prosthesis and accessories: • covered only when the hair loss is the result of either chemptherapy and/or radiation treatment for malignant and non-malignant conditions, trichotillomania or alopecia • subject to medical and benefit criteria	90% after deductible

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M - FOP LABOR COUNCIL CIVILIAN
BCBSM Preferred RX Program
Effective Date: On or after January 2017
Benefits-at-a-glance

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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Copay	You pay $15 copay	You pay $15 copay plus an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	You pay $30 copay	You pay $30 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 90 day supply:** • You pay $15 copay • You pay $30 copay for brand name drugs	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	75% of approved amount less plan copay/ coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs

Features of your prescription drug plan

Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.

Features of your prescription drug plan

Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy, along with the preferred medications.** If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Clinical Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.

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Hearing Care Coverage
Effective Date: On or after January 2017
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Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.