



Michigan Catholic Conference Clergy Plan PPO Effective date of coverage: January 1, 2012 Benefits-at-a-Glance

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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 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.

Eligibility Information

Dependent

Subscriber's legal spouse

Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the last day of the month the dependent turns age 26

In-network

Out-of-network *

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

| | In-network | Out-of-network * |
|--|---|--|
| Deductibles | \$100 for one member, \$200 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office. | \$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible. |
| Fixed dollar copays | <ul style="list-style-type: none"> \$15 copay for office visits \$100 copay for emergency room visits | \$100 copay for emergency room visits |
| Percent copays Note: Copays apply once the deductible has been met. | <ul style="list-style-type: none"> 50% of approved amount for private duty nursing 10% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays. | <ul style="list-style-type: none"> 50% of approved amount for private duty nursing 30% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays. |
| Annual copay dollar 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 | \$500 for one member, \$1,000 for two or more members each calendar year | \$1,500 for one member, \$3,000 for two or more members each calendar year Note: Out -of-network copays also apply toward the in-network maximum. |
| Lifetime dollar maximum | None | |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.



In-network

Out-of-network *

Preventive care services

| | | |
|---|---|---|
| Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Gynecological exam | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Pap smear screening – laboratory and pathology services | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Well-baby and child care visits | 100% (no deductible or copay) <ul style="list-style-type: none"> • 6 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) | Not covered |
| Fecal occult blood screening | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Flexible sigmoidoscopy exam | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Prostate specific antigen (PSA) screening | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Routine mammogram and related reading | 100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay. | 70% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider. |
| | One per member per calendar year | |
| Colonoscopy – routine or medically necessary | 100% (no deductible or copay) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay. | 70% after out-of-network deductible |
| | One per member per calendar year | |
| CA-125 Test | 100% (no deductible or copay) one per member per calendar year Note: Professional services only. Facility services subject to criteria | Not covered |

Physician office services

| | | |
|---|---------------------------------|--|
| Office visits | \$15 copay per office visit | 70% after out-of-network deductible, must be medically necessary |
| Outpatient and home medical care visits | 90% after in-network deductible | 70% after out-of-network deductible, must be medically necessary |
| Office consultations | \$15 copay per office visit | 70% after out-of-network deductible, must be medically necessary |
| Urgent care visits | \$15 copay per office visit | 70% after out-of-network deductible, must be medically necessary |



In-network

Out-of-network *

Emergency medical care

| | | |
|--|--|--|
| Hospital emergency room | \$100 copay per visit (copay waived if admitted or for an accidental injury) | \$100 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

| | | |
|-----------------------------------|---------------------------------|-------------------------------------|
| 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

| | | |
|-----------------------------|--|-------------------------------------|
| Prenatal and postnatal care | 100% (no deductible or copay) Includes covered services provided by a certified nurse midwife | 70% after out-of-network deductible |
| Delivery and nursery care | 90% after in-network deductible Includes covered services provided by a certified nurse midwife | 70% after out-of-network deductible |

Hospital care

| | | |
|---|---------------------------------|-------------------------------------|
| 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 | 70% after out-of-network deductible |
| Unlimited days | | |
| 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

| | | |
|---|---------------------------------|---------------------------------|
| Skilled nursing care – must be in a participating skilled nursing facility | 90% after in-network deductible | 90% after in-network deductible |
| Limited to a maximum of 120 days per member per calendar year | | |
| Hospice care Note: Includes Nursing home care with hospice support | 100% (no deductible or copay) | 100% (no deductible or copay) |
| 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 and provided by a participating home health care agency | 90% after in-network deductible | 90% after in-network deductible |
| Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers | 90% after in-network deductible | 90% after in-network deductible |

Surgical services

| | | |
|--|---------------------------------|-------------------------------------|
| 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) | 70% after out-of-network deductible |
| Voluntary abortion | Not covered | Not covered |
| Voluntary sterilization | Not covered | Not covered |

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In-network

Out-of-network *

Human organ transplants

| | | |
|---|---------------------------------|--|
| Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% (no deductible or copay) | 100% (no deductible or copay) – in designated facilities only |
| Bone marrow transplants – when 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 | 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 abuse treatment

| | | |
|---|------------------------------------|---|
| Inpatient mental health care | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | |
| Inpatient substance abuse treatment | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | |
| Outpatient mental health care: • Facility and clinic | 90% after in-network deductible | 90% after in-network deductible, in participating facilities only |
| | 90% after in-network deductible ** | 70% after out-of-network deductible |
| Outpatient substance abuse 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) |

** Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

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In-network

Out-of-network *

Other covered services

| | | |
|--|--|--|
| Outpatient Diabetes Management Program (ODMP) Note: Effective July 1, 2011, 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) for diabetes self-management training | 70% after out-of-network deductible |
| Allergy testing and therapy | 100% (no deductible or copay) | 70% after out-of-network deductible |
| Chiropractic spinal manipulation | 100% (no deductible or copay) Limited to a combined maximum of 24 visits per member per calendar year | 70% after out-of-network deductible |
| Outpatient physical, speech and occupational therapy – provided for rehabilitation | 90% after in-network deductible Limited to a combined maximum of 60 visits per member per calendar year | 70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. |
| Durable medical equipment | 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 | 50% after in-network deductible | 50% after in-network deductible |

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Hearing Care Coverage Benefits-at-a-Glance

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| | Participating provider | Nonparticipating provider |
|---|------------------------|---------------------------|
| Member's responsibility (deductible and copay) | | |
| 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.

| | | |
|---|-------------------------|-------------|
| 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.