Michigan Catholic Conference – 11930-902 Retiree Lay PPO with Rx

Effective date of coverage: January 1, 2011

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 your summary plan description 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.

Community Blue℠ PPO Medical - Surgical Coverage

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

Note: Services from a provider for which there is no Michigan PPO network are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and provider's charge.

		In-network	Out-of-network
Deductibles (each calendar year)		$250 for one member, $500 for the family **Note:** Deductible waived if service is performed in a PPO physician's office, except for mental health/substance abuse.	$500 for one member, $1,000 for the family **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Copays	Fixed dollar copays	• $15 copay for office visits • $100 copay for emergency room visits	$100 copay for emergency room visits
	Percent copays	• 50% of approved amount for private duty nursing • 20% of approved amount for mental health and substance abuse • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 40% of approved amount for mental health and substance abuse • 40% of approved amount for most other covered services
Annual copay dollar maximums (each calendar year) – **excludes** fixed dollar copays and private duty nursing percent copays		$1,000 for one member, $2,000 for the family	$3,000 for one member, $6,000 for the family **Note:** Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximums		None	

Preventive care services

	In-network	Out-of-network
Health maintenance exam	100%, one per calendar year	Not covered
Routine gynecological exam	100%, one per calendar year	Not covered
Pap smear screening	100%, one per calendar year	Not covered
Well-baby & child care visits	100% • 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%	Not covered
• Fecal occult blood screening • Flexible sigmoidoscopy exam	100%, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	100%, one per calendar year	Not covered
Routine mammograms – one per calendar year	100%	60% after deductible
Routine screening colonoscopy – one per calendar year	100%	60% after deductible

Physician office services

	In-network	Out-of-network
• Office visits • Office consultations • Urgent care visits	$15 copay per office visit	60% after deductible, must be medically necessary

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	In-network	Out-of-network
Physician office services, *continued*		
Outpatient & home medical care visits	80% after deductible	60% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	
Ambulance services – must be medically necessary	80% after deductible	80% after deductible
Diagnostic services		
• Laboratory & pathology services • Diagnostic tests & x-rays • Therapeutic radiology	80% after deductible	60% after deductible
Routine screening CA-125 tests	100%, one per calendar year	Not covered
Maternity services provided by a physician or certified nurse midwife		
Prenatal & postnatal care	100%	60% after deductible
Delivery & nursery care	80% after deductible	60% after deductible
Hospital care		
Semiprivate room, general nursing care – unlimited days	80% after deductible	60% after deductible
• Inpatient consultations • Chemotherapy	80% after deductible	60% after deductible
Alternatives to hospital care		
Skilled nursing care – up to 120 days per calendar year	80% after deductible	80% after deductible
Hospice care (includes coverage for nursing home care with hospice support) – limited to dollar maximum adjusted periodically	100%	100%
• Home health care • Home infusion therapy	80% after deductible	80% after deductible
Surgical services		
Surgery – includes related surgical services	80% after deductible	60% after deductible
Presurgical consultations	100%	60% after deductible
• Voluntary sterilization • Voluntary abortions	Not covered	Not covered
Human organ transplants		
Specified human organ transplants *– in designated facilities **only**	100% – in designated facilities **only**	
• Bone marrow transplants * • Specified oncology clinical trials • Kidney, cornea & skin transplants	80% after deductible	60% after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care & substance abuse treatment – unlimited days	80% after deductible	60% after deductible
Outpatient mental health care	80% after deductible **	60% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after deductible **	80% after deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP)	80% after deductible	60% after deductible
Allergy testing & therapy	100%	60% after deductible
Chiropractic spinal manipulation – up to 24 visits per calendar year	100%	60% after deductible
Outpatient physical, speech & occupational therapy – **combined** 60-visit maximum per calendar year	80% after deductible	60% after deductible
• Durable medical equipment • Prosthetic & orthotic appliances	80% after deductible	80% after deductible
Private duty nursing	50% after deductible	50% after deductible
Blue Preferred® Rx Prescription Drug Coverage	**Network pharmacy**	**Non-network pharmacy**
Copays	$7 for Tier 1 (generic) drugs, $30 for Tier 2 (formulary brand) drugs and $50 for Tier 3 (nonformulary brand) drugs **Mail order:** 90-day supply – two times one month copay	$7 for Tier 1 (generic) drugs, $30 for Tier 2 (formulary brand) drugs and $50 for Tier 3 (nonformulary brand) drugs ***plus*** an additional 25% of BCBSM approved amount
Hearing Care Coverage – covered once every 36 months	**Participating provider**	**Nonparticipating provider**
• Audiometric exam • Hearing aid evaluation • Hearing aid, including binaural hearing aids • Hearing aid conformity test	100%	Not covered

* Must be coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)

** Effective January 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 $15 office visit copay.

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