Blue Cross Blue Shield of Michigan

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

A0EUX6 - UTILITY WORKERS UNION OF AME
47953-001
Effective Date: On or after January 2014
Benefits-at-a-Glance

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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided - select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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.

Services from a provider for which there is no Michigan PPO network and services from an out-of-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 nonparticipting provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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

Benefits	In-Network	Out-of-Network
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year
Flat dollar copays	• $20 copay for office visits • $20 copay for chiropractic services and osteopathic manipulative therapy • $50 copay for emergency room visits	$50 copay for emergency room visits

Benefits	In-Network	Out-of-Network
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 10% of approved amount for mental health care and substance abuse treatment • 10% of approved amount for most other covered services (coinsurance waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 20% of approved amount for mental health care and substance abuse treatment • 20% of approved amount for most other covered services
Annual out-of-pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including prescription drug copays and coinsurance amounts, if applicable	$1,000 for one member $2,000 for two or more members each calendar year	$2,000 for one member, $4,000 for two or more members each calendar year **Note:** Out-of-network cost-sharing amounts also apply 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), 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
Voluntary sterilizations for females	100% (no deductible or copay)	80% 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)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay) • 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

Benefits	In-Network	Out-of-Network
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 coinsurance.	80% after out-of-network deductible **Note:** Out-of-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 coinsurance.	80% 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	$20 copay for office visit	80% after out-of-network deductible
	---none---	
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay for office visit	80% after out-of-network deductible
	---none---	
Urgent care visits - must be medically necessary	$20 copay for office visit	80% after out-of-network deductible
	---none---	

Emergency medical care

Benefits	In-Network	Out-of-Network
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 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	80% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician

Benefits	In-Network	Out-of-Network
Prenatal care visits	100% (no deductible or copay)	80% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay)	80% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible	80% 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	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	90% after in-network deductible	80% after out-of-network deductible
Chemotherapy	90% after in-network deductible	80% 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	90% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year.	
Hospice care	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
Infusion therapy - must be medically necessary and given by **participating** infusion therapy providers **Note:** Benefits for infusion therapy services include covered services in a **participating** freestanding Ambulatory Infusion Centers (AICs).	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	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	80% after out-of-network deductible
Voluntary sterilization for males **Note:** See "Preventive care services" section for voluntary sterilizations for females.	90% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-Network	Out-of-Network
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	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	80% after out-of-network deductible

Mental health care and substance abuse treatment

Benefits	In-Network	Out-of-Network
Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	80% 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 designated facilities **only**
• Physician's office	90% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities **only**	90% after in-network deductible	80% 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
Treatment of Applied Behavioral Analysis (ABA) for Autism limited to 25 hours of direct line therapy per week per member through age 18. Physical, Occupational, and Speech Therapy limits are combined with Rehabilitation services limits. ABA services not available outside of Michigan.	90% after in-network deductible	90% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder - through age 18	90% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is limited to the same annual **combined** limit as for physical, speech and occupational therapy for other diagnoses.	
Other covered services, including mental health services, for Autism Spectrum Disorder	90% after in-network deductible	80% after out-of-network deductible

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 a network provider. **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	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay copay per office visit	80% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy.	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year, **combined** with therapies for autism spectrum disorder	
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 a 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

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Blue Preferred Rx® Prescription Drug Coverage

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. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many 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 Medco. (Medco 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**. Log in under "I am a Member." 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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days) once applicable deductible has been met.

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, may be 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

Copays	Network pharmacy	Non-network pharmacy
Generic drugs	$10 copay	$10 copay plus an additional 25% of the BCBSM approved amount for the drug
Brand Name Drugs	$40 copay	$40 copay plus an additional 25% of the BCBSM approved amount for the drug
Mail order prescription drugs	Twice the copay amount	Not Covered

Covered services

	Network pharmacy	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements, and vitamins	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved **brand name** prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are devices are not covered)	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs. **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs - up to 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

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.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

Features of your prescription drug plan

	Network pharmacy	Non-network pharmacy
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com** . Log in under *I am a Member* and click on *Prescription Drugs*.	
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. 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. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.	
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.	