

## Your Benefit Chart

The information contained herein provides a general summary of your group's health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to BCBSM certificates, riders, plan modifications and/or changes that your group may be making to your coverage. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. You can also contact your health care administrator or call the customer service phone number printed on the back of your ID card if you have additional questions regarding your health care benefits.

**Group:** MBPA/MARION PUBLIC SCHOOLS

**Group No:** 58368014

Please click here for your certificate. [Community Blue Certificate](#)

**Note:** Services from a provider for which there is no 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. 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. There is a \$5 million lifetime maximum per member for all other covered services and as noted for individual services.

### Member's Responsibility (Deductible, Copay and Maximums)

Benefits	In-Network	Out-of-Network
Deductible	None	\$250 per member or \$500 for the family per calendar year
Fixed dollar copays	\$10 copay per visit for specific office services	Not applicable
Emergency services copay	\$50 copay for emergency services, waived if admitted or for an accidental injury	\$50 copay for emergency services, waived if admitted or for an accidental injury
Percent copays	Covered - 100 percent of the approved amount	20 percent of the approved amount
Mental health percent copay	50 percent of the approved amount	50 percent of the approved amount
Private duty nursing copay	50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible
Copay dollar maximums, excludes fixed dollar copays and mental health, substance abuse and private duty nursing percent copays.	None	\$2,000 per member or \$4,000 for the family per calendar year
<p>\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted for individual services</p>		

**Preventive care services - \$500 annual maximum for covered preventive care services**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Health maintenance exam - includes chest x-ray, EKG and select lab procedures, one per calendar year	Covered - 100 percent of the approved amount	Not covered
Gynecological exam - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Pap smear screening (laboratory and pathology services) - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Well-baby and child care 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 examination benefit	Covered - 100 percent of the approved amount	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered - 100 percent of the approved amount	Not covered
Fecal occult blood screening - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Flexible sigmoidoscopy exam - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100 percent of the approved amount	Not covered

**Mammography**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Routine mammogram - One per calendar year, no age restrictions	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

**Physician office services**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Office visits  <b>Note:</b> Must be medically necessary for out-of-network services.	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible
Outpatient and home medical care visits  <b>Note:</b> Must be medically necessary for out-of-network services.	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Office consultations  <b>Note:</b> Must be medically necessary for out-of-	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible

network services.

Urgent care visits	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible
<b>Note:</b> Must be medically necessary for out-of-network services.		

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### **Emergency medical care**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital emergency room	\$50 copay for emergency services, waived if admitted or for an accidental injury	\$50 copay for emergency services, waived if admitted or for an accidental injury
Ambulance services - must be medically necessary	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount

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### **Diagnostic services**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Laboratory and pathology services	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Diagnostic tests and x-rays	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Therapeutic radiology	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

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### **Maternity services provided by a physician or certified nurse midwife**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Prenatal and postnatal care - includes covered services provided by a certified nurse midwife	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Delivery and nursery care - includes covered services provided by a certified nurse midwife	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

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### **Hospital care**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Semiprivate room - inpatient physician care, general nursing care, hospital services and supplies - unlimited days	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

**Note:** Maternity care and routine newborn nursery care during a mother's eligible hospital stay. Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with

childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

**Note:** Non-emergency services must be rendered in a participating hospital.

Inpatient consultations	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Chemotherapy	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

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**Alternatives to hospital care**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Skilled nursing care - up to 120 days per calendar year	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
Hospice care - 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	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
Home health care - must be medically necessary	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
Home infusion therapy - must be medically necessary	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount

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**Inpatient Hospital Benefits Not Covered**

Services that may be medically necessary but can be provided safely in an outpatient or office location; except when noted by other benefit coverage

Services of physicians and surgeons not employed by the hospital

Custodial care or rest therapy

Psychological tests if used as part of, or in connection with, vocational guidance training or counseling

Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting a medical condition such as:

- Bleeding or clotting abnormalities
- Unstable angina
- Severe respiratory disease
- Known reaction to analgesics, anesthetics, etc.

Those procedures include:

- Alveoplasty
- Diagnostic X-rays
- Multiple extractions or removal of unerupted teeth
- Gingivectomy

**Note:** Medical records must verify the patient's concurrent hazardous medical condition.

Services covered under any other Blue Cross Blue Shield contract or under any health care benefits plan

Screening services

Artificial and endodontic transplants and related services, including repair and maintenance of implants and surrounding tissue

Those for care that is not considered acute, such as:

- Observation
- Dental treatment, including extraction of teeth, except as otherwise noted in this Certificate
- Diagnostic evaluations
- Lab exams
- Electrocardiography
- Weight reduction
- X-ray, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience items

Those mainly for physical therapy, speech and language pathology services or occupational therapy; except when noted by other benefit coverage

**Surgical services**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<p>Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility.</p> <p><b>Note:</b> Benefit also includes related surgical services such as colonoscopy services.</p>	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Presurgical consultations	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Voluntary sterilization	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

Voluntary abortions	Not covered	Not covered
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**Human organ transplants**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Specified human organ transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)  Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	Covered - 100 percent of the approved amount	Covered - in designated facilities only
Bone marrow transplants - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Kidney, cornea and skin transplants	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Specified oncology clinical trials	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

**Mental health care and substance abuse treatment**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Inpatient mental health care	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible
Inpatient substance abuse treatment - limited to \$15,000 each calendar year with a lifetime maximum of \$30,000	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible
Outpatient mental health care Facility and clinic Physician's office Note: Deductible waived if service is performed in a PPO physician's office.	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible
Outpatient substance abuse treatment (in approved facilities) - up to the state, dollar amount that is adjusted annually	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible

**Outpatient Hospital Benefits Not Covered**

Outpatient inhalation therapy  
 Cardiac rehabilitation services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable  
 Sports medicine, pain management, patient education or home exercise programs

**Other covered services**

<b>Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Outpatient diabetes management program (ODMP)	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Allergy testing and therapy	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Chiropractic spinal manipulation - limited to a combined maximum of 24 visits per member per calendar year	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient physical, speech and occupational therapy - limited to a combined maximum of 60 visits per member per calendar year	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Contraceptive injections	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Prescription contraceptive devices	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Durable medical equipment	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
Prosthetic and orthotic appliances	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Private duty nursing	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible

**Physician and Other Professional Benefits Not Covered**

Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan

Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children

Services for cosmetic surgery when performed primarily to improve appearance

Health care services provided by persons who are not legally qualified or licensed to provide them

Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization), unless otherwise noted as an included benefit

Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit

Weight loss programs

Contraceptive devices and medications used for the express purpose of preventing pregnancy, unless otherwise noted as an included benefit

Rest therapy or services provided to you while you are in a convalescent home, long, term care facility, nursing home, rest home or similar nonhospital institution

Services, care, supplies or devices not prescribed by a physician

Services provided during nonemergency medical transport

Experimental treatment

Hearing aids or services to examine, prepare, fit or obtain hearing aids, unless otherwise noted as an included benefit

Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens

Hospital services, including services provided by hospital employees

Drugs, medical appliances, materials or supplies or blood transfusions

Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, except for:

- Surgery directly to the temporomandibular joint (jaw joint)
- Diagnostic X-rays
- Arthrocentesis
- Physical therapy

**Note:** The above restriction applies to any condition causing the temporomandibular joint (jaw joint) dysfunction.

Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)

Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

Infertility services that do not treat a medical condition other than infertility This can include services such as:

- Sperm washing
- Post coital test
- Monitoring of ovarian response to ovulatory stimulants
- In vitro fertilization
- Ovarian wedge resection or ovarian drilling
- Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
- Diagnostic studies done for the sole purpose of infertility assessment
- Any procedure done to enhance reproductive capacity or fertility

**Note:** You or your physician can call us to determine if other proposed services are a covered benefit under your Certificate.

Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs

Screening services (except as otherwise stated)

Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate

Those available in a hospital maintained by the state or federal government, unless payment is required by law

Those payable by government, sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services is payable if federal laws require the government, sponsored program to be secondary to this coverage.

Any services not listed in your Certificate as being payable

**Blue Preferred Rx® Prescription Drug Coverage**

**Note:** Effective February 1, 2010, the mail order pharmacy for specialty drugs changed to 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 Blue 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 866 - 515 - 1355.

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).

**Blue Preferred RX Prescription Drug Coverage**

<b>Benefits</b>	<b>Network Pharmacy</b>	<b>Non-network Pharmacy</b>
Copay	Covered - \$10 copay	Covered - \$10 copay, plus 25 percent of the approved amount
Brand name drugs	Covered - Increase copay by \$10 for brand name drugs	Covered - Increase copay by \$10 for brand name drugs, plus 25 percent of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Covered - Copay is a separate copay amount for covered drugs up to	Not covered

30 day supply for prescription or refill.  
 Copay is double for drugs between 31 and 90 day supply for prescription or refill.

**Note:** If your prescription is filled by any type of network pharmacy, and you request the brand - name drug when a generic equivalent is available on the BCBSM 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.

**Prescription covered services**

<b>Benefits</b>	<b>Network Pharmacy</b>	<b>Non-network Pharmacy</b>
FDA-approved drugs	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
State - controlled drugs	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs <b>Note:</b> Needles and syringes have no copay.	Covered - 100 percent less plan copay for the insulin or other covered injectable legend drug	Covered - 75 percent less plan copay for the insulin or other covered injectable legend drug
Contraceptive medications	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
Mail order (home delivery) prescription drugs - up to a 90 - day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered - 100 percent less plan copay	Not covered

**Prescription Drugs Not Covered**

Any contraceptive medications and devices, whether over-the-counter or FDA-approved or not, regardless of the reason they were prescribed or their intended use, unless otherwise noted as an included benefit

Therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self - administered chemotherapeutic drugs

Drugs prescribed for cosmetic purposes

The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order

Any vaccine given solely to resist infectious diseases

Administration of covered drugs (e.g., injections)

Non-self-administered injectable drugs

More than a 30-day supply of a covered drug. We may make exceptions for certain maintenance drugs or for

drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

More than 12 doses of an impotence drug in a 30-day period unless otherwise noted or excluded. If you have a BCBSM mail order drug program, no more than 36 doses in a 90-day period

More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains preauthorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM Web site at bcbsm.com.

Any drug we determine to be experimental or investigational

Any covered drug entirely consumed at the time and place of the prescription

Anything other than covered drugs and services

Diagnostic agents

Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off - label use of a drug or device. Some chemotherapeutic drugs may be subject to prior authorization review.

Drugs that are not labeled FDA-approved, except for state - controlled drugs and insulin, or such drugs the BCBSM designates as covered

Covered drugs or services dispensed to a member when such services are benefits under other Blue Cross and Blue Shield certificates

Drugs or services obtained before the effective date of this contract, or after the contract ends

Nonpreferred co - branded drugs, unless they are preauthorized

Claims for covered drugs or services submitted after the applicable time limit for filing claims

Support garments or other nonmedical items

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