Blue Cross Blue Shield of Michigan

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

Michigan Catholic Conference
Group Number: 71755 Package Code(s): 030
Section Code(s): 1000
PPO - PPOHD, Hearing, Vision (Exam only)
Effective Date: 01/01/2018
Benefits-at-a-glance

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$5,000 per member $10,000 per family	$10,000 per member $20,000 per family
Copays • Fixed Dollar Copays	$25 copay for : • Office visits • Chiropractic spinal manipulations $50 copay for : • Urgent care services $200 copay for : • Facility medical emergency	$200 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	30%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$6,350 per member $12,700 per family Includes Deductible, Coinsurance and Copays	$12,700 per member $25,400 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Not Covered	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	Covered - 60% after deductible
Office Consultations	Covered - 100% after $25 copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $200 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $200 copay; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after $50 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 70% after deductible	Covered - 70% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 70% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 70% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 70% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 70% after deductible	Covered - 60% after deductible

Hospital Care * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 70% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 70% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 70% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 70% after deductible	Covered - 70% after deductible

Surgical Services * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 70% after deductible	Covered - 60% after deductible
Sterilization excludes reversal sterilization	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 70% after deductible	Covered - 60% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 70% after deductible	Covered - 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 70% after deductible	Covered - 60% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 70% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 70% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 70% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 70% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100% after $25 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 70% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 70% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 50%	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy	Covered - 70% after deductible	Covered - 60% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Blue Distinction Specialty Care

Specialty	BDC Plus Center	BDC Center	In-Network	Out-of-Network
Bariatric Surgery	Covered - 70% after deductible	Covered - 70% after deductible	Covered - 60% after deductible	Covered - 60% after deductible

Blue Distinction Centers identifies facilities that demonstrate proven expertise in delivering safe, effective, high-quality care for select specialty procedures.

Blue Distinction Centers+ are Blue Distinction Centers that are also recognized for their expertise and cost-efficiency in delivering safe, effective, high-quality specialty care.

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 nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Michigan Catholic Conference
Group Number: 71755 Package Code(s): 030
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Vision Coverage - Blue Vision - Exam Only
Effective Date: 01/01/2018
Benefits-at-a-glance

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Value added discounts

Laser VisionCare℠ – VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's Web site at **vsp.com** to learn more about this exciting program.
Prescription glasses – Your plan provides unlimited use of the 20 percent discount on glasses as long as an eye exam has been performed in the last 12 months.
Contact lenses – VSP also offers valuable savings on annual supplies of certain brands of contacts. Visit **vsp.com** or ask your doctor for details.

Locating your VSP network doctor

When you obtain services from a VSP network doctor, you get the most value from your VSP benefit. VSP offers two convenient ways to locate a VSP doctor near your home or office, or to verify your doctor is a VSP network doctor:
- Visit the VSP Web site at **vsp.com**
- Call VSP Member Services at **1-800-877-7195**

Member's responsibility (copayments)

Benefits	VSP Network Doctor	Non-VSP Provider
Eye Exam	$25 copayment	Reimbursement up to $35 less $25 copayment
Lenses and/or frames	Not applicable	Not applicable

Eye exams

Benefits	VSP Network Doctor	Non-VSP Provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered - $25 copayment	Covered - reimbursement up to $35 less $25 copayment

Lenses and frames

Benefits	VSP Network Doctor	Non-VSP Provider
Standard lenses	Not covered **Note:** If you choose to purchase standard lenses, your plan provides a 20 percent discount off the VSP doctor's fees for prescription lenses (when a complete pair of glasses is purchased). To receive the discount, lenses must be purchased within 12 months of a covered eye exam, and only through the VSP doctor who performed the exam.	Not Covered
Standard frames	Not Covered **Note:** If you choose to purchase standard frames, your plan provides a 20 percent discount off the VSP doctor's fees for prescription lenses (when a complete pair of glasses is purchased).	Not Covered

Contact lens evaluation and fitting

Benefits	VSP Network Doctor	Non-VSP Provider
Contact lenses: • Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary) • Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Not Covered **Note:** If you choose to purchase contact lenses, whether medically necessary or elective, your plan provides a 15 percent discount off the cost of your contact lens exam (discount does not apply to eyewear). Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.	Not Covered

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Hearing Care Coverage
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Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Coverage
Frequency Limitation	Once every 36 months
Audiometric Exam	Covered - 100%
Hearing Aid Evaluation	Covered - 100%
Hearing Aid	Covered - 100% Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.
Hearing Aid Conformity Test	Covered - 100%