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): 050, 060
Division Code(s): 1000, 4000
PPO - HDHP PPO, Rx3, Hearing, Vision (Exam only)
Effective Date: 01/01/2027
Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$5,000 per member $10,000 per family	$10,000 per member $20,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	30%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$7,000 per member $14,000 per family Includes Deductible, Coinsurance and Copays	$14,000 per member $28,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - 1 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 - 2 per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - 1 per calendar year	Covered - 100%	Not Covered

Benefits	In-Network	Out-of-Network
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Not Covered	Not Covered
Prostate Specific Antigen (PSA) screening - 1 per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - 1 per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 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	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 70% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 70% after deductible	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 70% after deductible	Not Covered
Office Consultations	Covered - 70% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 70% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 70% after deductible	Covered - 70% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 70% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 70% after deductible	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

Benefits	In-Network	Out-of-Network
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% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 70% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to 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
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	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% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 70% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 70% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 70% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 70% after deductible	Covered - 60% after deductible

Benefits	In-Network	Out-of-Network
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 70% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	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 Services Limited to a maximum of 24 visits per calendar year	Covered - 70% after deductible	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% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 70% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 70% after deductible	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

Blue Distinction Specialty Care

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.

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

Michigan Catholic Conference
Group Number: 71755 Package Code(s): 050, 060
Division Code(s): 1000, 4000
Hearing Care Coverage
Effective Date: 01/01/2027
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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

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

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

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Michigan Catholic Conference
Group Number: 71755 Package Code(s): 050, 060
Division Code(s): 1000, 4000
Prescription Drugs
Effective Date: 01/01/2027
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$5,000 per member $10,000 per family
Retail - 30-day supply	20% coinsurance after deductible - Generic drugs 30% coinsurance after deductible - Preferred brand drugs 40% coinsurance after deductible - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	20% coinsurance after deductible - Generic drugs 30% coinsurance after deductible - Preferred brand drugs 40% coinsurance after deductible - Non-Preferred brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: 20% coinsurance after deductible - Generic drugs 30% coinsurance after deductible - Preferred brand drugs 40% coinsurance after deductible - Non-Preferred brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Additional Services	
Oral and Injectable Contraceptives	Not Covered

Benefits	Coverage
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Not Covered
Impotency Drugs	Not Covered
Infertility Drugs	Not Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan

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 prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

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Vision Coverage - Blue Signature VSP Exam Only
Effective Date: 01/01/2027
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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 copay	Reimbursement up to $35 less $25 copay
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 copay	Covered - reimbursement up to $35 less $25 copay
	Once every 12 months	

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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