BlueCard Out-of-State Health Plan

Member Handbook

Effective: Jan. 1, 2024

Welcome

Thank you for choosing Blue Cross Blue Shield of Michigan. This Member Handbook will help you and your family get the most from your health plan. By being well-informed, you'll have the confidence and security of knowing that health care coverage is available when you need it.

This handbook gives an overview of your health care coverage. For more details about your coverage:

- Visit **bcbsm.com** and click *login.*
- Register to create an account.

If you have technical difficulties, call Blue Cross Web Support at 1-888-417-3479.

The information in this handbook is a summary of your group's health care benefits. It is not a contract. It may not reflect additional limitations and exclusions that apply to paid services or the most recent updates to the Blue Cross certificates, riders, plan modifications or changes that your group may be making to your coverage. Contact your health care administrator or call the Customer Service number printed on the back of your member ID card if you have additional questions about your health care benefits.

Thank you for being a member of Blue Cross.

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Getting started

Your member ID card

Confidence comes with every card®.

You should receive your Blue Cross member ID card in the mail.

Your member ID card tells doctors and other health care providers what your health plan includes and what Blue Cross Blue Shield of Michigan pays.

NOTE: All cards will show the subscriber's name, even those issued to family members. If you aren't the subscriber, your card won't have your name on it.

Below is a sample member ID card that highlights information you may need.

❶ Member name: The subscriber's name

❷ Member ID: The subscriber's assigned contract number, which allows health care providers to identify you and your benefits

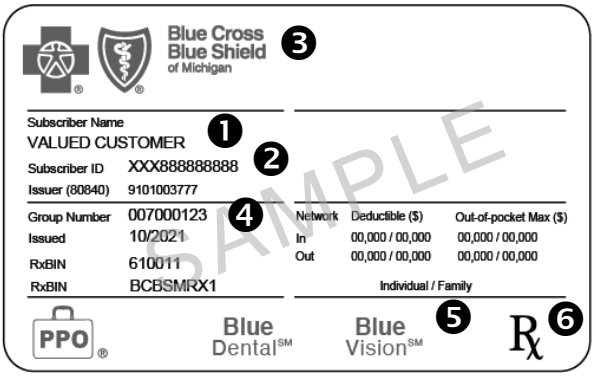
❸ Issuer: Identifies you as a Blue Cross member from Michigan to out-of-state providers

❹ Group number: Identifies your employer group

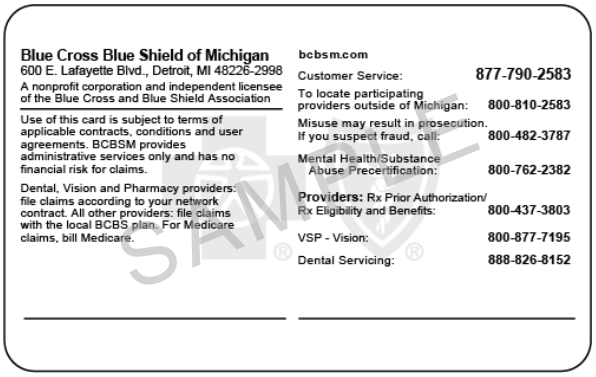
❺ & ❻ These icons are present if your coverage includes dental, vision or prescription drugs

Customer service phone numbers for you and your providers are on the back of your member ID card.

Card front



Card back



Lost or stolen cards

You can replace lost or stolen cards by calling Customer Service at the toll-free phone number on the back of your ID card. You can also order member ID cards at **bcbsm.com**, or use the mobile app to request additional cards or view a virtual one.

If your card is lost or stolen, you can still receive services, but you should report the loss immediately to your employer and Blue Cross.

You can also access your member ID card through the mobile app or your online member account.

Getting started

Web or mobile, get the most from your health plan

Health care can be confusing. To help you understand and manage your costs and care, we offer a wide range of tools through your online member account at **bcbsm.com**.

Register for your online member account

It only takes a few minutes to activate your account. Go to **bcbsm.com** and click *LOGIN* and follow the prompts.

You can also access your plan information by using our app. To get our mobile app, search “BCBSM” in the App Store® or on Google Play™.

What can you find online or using the mobile app?

My Coverage – Find detailed health plan information, who is on your health plan, what we pay for, what you pay for and more.

My Claims – See a list of all claims.

ID Card – Request additional member ID cards or view a virtual one.

Find Care – This includes hospitals, urgent care, behavioral health services and 24-Hour Nurse Line.

Programs and Services – Find health care services and well-being resources that are available through your plan.

Forms and Documents – Get claim and reimbursement forms and many other helpful resources to manage your health care benefits and care.

Discounts – You’ll have access to money-saving programs, such as Blue365®. This national program offers access to discounts and savings from selected companies on health-related products and services.

Search for doctors and hospitals

Your account helps you understand your choices about who to see and where to go for care in your plan's network.

Look up a doctor’s name or specialty, places for health care services by name or type, or costs for a procedure.

If you want a pediatrician near your child’s day care center or a primary doctor closer to work, reset the location to get a broader list of in-network doctors.

Selecting the doctor's name shows you:

- Office location
- Office hours
- Health care plans accepted
- If vitual care is available
- Specialties
- If new patients are accepted
- Languages spoken
- Group and hospital affiliations
- Board certifications

Review the profiles of your top choices so you can determine the right doctor for you.

Compare costs for services and procedures

Your account gives prices for many health care services, based on actual costs. See the average cost for a service and how it can differ by doctor, location or type of facility.

Costs can vary. Sometimes you can save money by driving 15 minutes more or having your procedure at an outpatient facility rather than in a hospital.

Plan ahead for surgeries

Get an idea of the costs you can expect for surgery. Let’s say your doctor recommends knee replacement surgery. Your account sums up the estimated cost for each service involved with your procedure — from your first doctor visit to post-surgery physical therapy. With this information, you can see how long it could take and how much it may cost to have your knee replaced.

You’ll also see where you can save money. Using our example, you may find that six weeks of physical therapy costs less at a nearby outpatient clinic than the hospital. Knowing costs ahead of time helps you plan for care and manage your benefits.

You have the power to choose.

Use your account to explore options and costs, and talk with your doctor to make informed decisions about your care.

Your online member account is your health care resource for coverage and care.

Using your benefits

Your BlueCard Out-of-State coverage

Your medical coverage is easy to use with our PPO plan. To get the most from it, you'll need to know how your health plan works and where you can use it to receive prompt, quality medical care.

The health plan gives you and your family access to medical care through our extensive PPO network of doctors, hospitals and health care professionals. Network doctors and hospitals accept discounted fees for paid services, saving you money.

The advantages of using a PPO doctor

When you receive care from a PPO doctor, you pay lower out-of-pocket costs than if you use a doctor that's not in our network.

More than 80% of the doctors and 90% of the hospitals in the United States are part of our PPO network.

To see if a doctor, hospital or health care professional in your area participates with Blue Cross' PPO network, use our online search or mobile app — whether you're in Michigan or outside the state.

You can easily search for network doctors and hospitals at **bcbsm.com** or from the mobile app.

Seeing specialists and doctors outside the network

Choosing a specialist or doctor that isn't in Blue Cross' PPO network can affect your out-of-pocket costs. However, using a network provider saves you the most on your out-of-pocket costs.

Your benefits are provided through the preferred provider organization health care plan. This plan provides you with the highest level of benefit payment and limits your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the PPO health care provider network.

The level of a health care provider's participation affects your out-of-pocket costs. The levels are:

1. **Network providers (typically the lowest out-of-pocket costs)**
   To receive the highest benefit payment level, use health care providers in the PPO network. Network providers have signed agreements with Blue Cross, which means they agree to accept our allowed amount for a benefit as payment in full in your health plan. You'll only pay for the in-network deductibles, coinsurances and copayments required by your coverage.

   Ask your physician if they are in the Blue Cross PPO network. If you need help locating a network provider, call the Customer Service number on the back of your Blue Cross member ID card or visit **bcbsm.com**.

   When you go to a Blue Cross PPO network provider, you don't have to send us a claim. These providers submit claims for you, and they're paid directly by us.

2. **Non-PPO network but participating providers (lower out-of-pocket costs)**
   Although many providers are part of our PPO network, you can visit a non-PPO network provider and still receive coverage for services under your health plan.

   Participating providers have signed agreements to accept our allowed amount as payment in full for a benefit that's included in your health plan. However, they aren't part of the PPO network, so you must pay any required copayments and a higher deductible and coinsurance for your care.

   You don't have to submit claims when you go to a participating provider. These providers, like PPO network providers, submit claims for you and the providers are paid directly by us.

3. **Nonparticipating providers (highest out-of-pocket costs)**
   Nonparticipating providers haven't signed agreements with Blue Cross. This means they might not choose to accept our allowed amount as payment in full for your health care services.

   If your health care providers don't participate with Blue Cross, ask if they'll accept the amount we approve as payment in full for the services you need. This is called participating on a "per-claim" basis and means the providers will accept the allowed amount as payment in full for the specific services. You're responsible for any deductibles, coinsurances and copayments required by your health plan and charges for noncovered services.

   You're usually required to pay nonparticipating providers directly and then submit claims to us for reimbursement. Remember, the amount we reimburse you may be less than the amount your provider charged. You're responsible for the amount the provider charged above our allowed amount.

Using your benefits

Care away from home

Within the U.S.
When you're traveling, you're covered through our **BlueCard®** program. Blue Cross Blue Shield plans have the largest hospital and physician networks in the U.S., with 97% of all U.S. hospitals and 85% of physicians. No matter where you live, work or travel, Blue Cross members, through BlueCard, can receive quality care. However, if the doctor or hospital is out of network, you could pay higher out-of-pocket costs.

To find a doctor or hospital outside Michigan, use the Find a Doctor search tool at **bcbs.com**, or call **1-800-810-2583**.

Outside the U.S.
If you're traveling or living outside the country, **Blue Cross Blue Shield Global® Core** gives you access to a worldwide network of traditional inpatient, outpatient and professional health care providers. The program includes a broad range of medical assistance and claim support services for members traveling or living in countries outside your service area. For more information, visit **bcbsglobalcore.com**.

Show your Blue Cross member ID card to your doctor or health care provider to verify your PPO benefits.

Choosing the right place for care

We've got you covered with care that's always there. When it's not an emergency, you have smart choices for care that will help you get the care you need, when you need it.

PRIMARY CARE PROVIDER	24-HOUR NURSE LINE	VIRTUAL CARE	WALK-IN CLINICS	
			RETAIL HEALTH CLINIC	URGENT CARE CENTERS
$	$0	$	$-$$	
AVERAGE WAIT TIME FOR CARE 30 minutes	AVERAGE WAIT TIME FOR CARE 1 minute	AVERAGE WAIT TIME FOR CARE 10 minutes	AVERAGE WAIT TIME FOR CARE 30 to 60 minutes	
APPOINTMENT REQUIRED? Yes	APPOINTMENT REQUIRED? No	APPOINTMENT REQUIRED? No	APPOINTMENT REQUIRED? No	
AVAILABLITY In person By phone Virtually	AVAILABLITY By phone	AVAILABLITY Virtually through the Teladoc Health® app	AVAILABLITY In person	
TREATMENT Start here when you want to talk with a doctor you know and trust	TREATMENT When you have questions about an illness or injury, anytime day or night	TREATMENT When you want to talk to a doctor or therapist virtually from your mobile device or telephone	TREATMENT For a quick, in-person evaluation to get minor health care and a prescription at one location	TREATMENT When your symptoms are a little more complicated and you need convenient, in-person care
• High-quality, comprehensive care • Knows you and your medical history and coordinates all your care • Many primary care offices offer virtual care, same-day appointments, extended hours and other services • You may have Virtual Primary Care through Teladoc Health® (for Blue Cross' PPO members*)	• No cost • Available by phone anytime, anywhere in the U.S. • Care provided by a registered nurse	• Video chat 24/7 with a provider or therapist anywhere in the U.S. • Send a visit summary to your primary doctor • Care provided by U.S. board-certified doctors and therapists • Prescriptions, if needed, can be sent to a pharmacy you prefer	• Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board-certified doctor	• Evening and weekend hours • Convenient locations • May offer labs and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms

*Remember to coordinate all your care with your primary care provider. Follow up with him or her after receiving care elsewhere.

Learn about care that's always there at **bcbsm.com/findcare**.

Teladoc Health is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

Using your benefits

Your pharmacy coverage

CVS Caremark administers your prescription drug plan. Whether you get your medications from a network pharmacy or through a mail-order service, you can rely on their clinical expertise to provide you with safe, high-quality prescriptions.

When you use an in-network pharmacy, you receive your prescriptions at a lower cost.

Co-payment levels are based on the CVS Caremark Standard Formulary Drug List. To verify coverage and check costs, visit the CVS Caremark member portal.

Caremark Co-Pays

#	Drug Tier	34-Day Supply Co-Pays	90-Day Supply Co-Pays
1.	Generic Medications	$10	$20
2.	Preferred Brand-Name Medications	$30	$60
3.	Non-Preferred Brand-Name Medications	$60	$120
4.	Bio-Tech Drugs/Specialty Drugs	$75	90-day supplies of bio-tech/specialty drugs are not offered
Annual Out-of-Pocket Co-Pay Maximum			
Individual $1000		**Family $2000**	

- Some formulary medications may require a Prior Authorization.
- Compound medications over $300 will require a Prior Authorization.
- 90-day supply medications (except for Bio-Tech/Specialty Drugs) may be filled at MSU Pharmacies or through CVS/caremark mail order. 90-day supplies of Bio-Tech/Specialty Drugs are not allowed.
- A non-preferred brand-name drug is one not included on the plan's formulary or list of preferred prescriptions. Non-preferred brand-name drugs have a higher coinsurance than preferred brand-name drugs. You pay more if you use non-preferred drugs than if you opt for generics and preferred brand-name drugs.
- In addition to the co-pay, you may be responsible to pay a dispense as written (DAW) pricing penalty. This means you may be responsible for the difference between the Preferred or Non-Preferred Brand Name Medication and the Generic Medication. Note : Certain medications are excluded from the pricing penalty. A DAW pricing penalty brand exception may be requested and reviewed by CVS/Caremark. Contact CVS/Caremark for details.
- If Preferred Brand-Name Medications or Non-Preferred Brand-Name Medications are selected you may have a pricing penalty. This means you will need to pay the difference in cost between the brand drug and generic drug. The pricing penalty does not apply to all medications and is not the same as a co-pay.
- Some specialty drugs will require step therapy.* Step therapy is a type of prior authorization that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary. Specialty injectable medications (medications for conditions such as Hepatitis B & C, RSV, Hemophilia, Immune Deficiency, and Osteo & Rheumatoid Arthritis) are only covered through CVS/caremark Specialty Pharmacy. Please call 1-800-237-2767 for more information on this benefit.

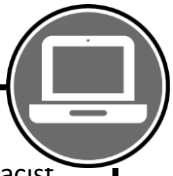
Consider generic drugs

Using generic prescription drugs keeps your costs down and gives you the same safe, effective medication as brand-name drugs. And, depending on your health plan, your copay may be lower.

More patients and doctors are turning to generic prescription drugs because they can save as much as 80% when compared to the cost of brand-name medications.

Are there differences between generic and brand-name drugs?
Name and price are the main differences. Like brand-name drugs, generics are FDA-approved and are:

- As safe and effective as brand-name drugs and often less expensive
- Made with the same active ingredients but may differ in color, size or shape
- Available in the same strength, purity, quality and dosage form as the brand-name product
- Often manufactured by the same company that makes the brand-name drug
- Are strictly regulated by the U.S. government and have FDA approval.
- Laboratory tested to ensure that the same amount of drug will be absorbed into the bloodstream as the brand-name drug



Find it online

Ask your doctor or pharmacist if a generic version of your medication is available and right for you. For more information, *contact CVS Caremark Customer Service at 1-800-565-7105 or caremark.com*.

Ways to fill your prescription

Whether you take medication regularly or need a prescription from time to time, your CVS Caremark prescription drug plan offers these convenient options:

- A national network of pharmacies
- Home Delivery at home, mail-order service that will deliver medications to your door
- Specialty Pharmacy with a convenient mail-order option for specialty drugs. Please call 1-800-237-2767 for more information on this benefit.
- MSU Health Care Pharmacy is able to fill up to a 90 day supply of your medication. To learn more, call 1-517-353-3500 or visit pharmacy.msu.edu.

Using your benefits

Retail pharmacies

You and your eligible family members can fill prescriptions at an in-network retail pharmacy.

- Present your CVS Caremark member ID card and prescription to the pharmacist.
- Provide the pharmacist with the patient's information.
- Your doctor may have sent an electronic prescription to the pharmacy.
- The pharmacist will use a computerized system to confirm your eligibility for benefits before telling you the copayment or deductible you'll be expected to pay. Your copay or deductible is dependent on your health plan benefit for each covered prescription order or refill.
- The pharmacy will submit the claim under your CVS Caremark coverage.

To locate a pharmacy, log in to your secure member account at **caremark.com** or on CVS Caremark mobile app:

Our mobile app is available through the App Store® and Google Play™. Simply search for "**CVS Caremark**" and make sure your phone or tablet is:

- An iPhone® or iPad® using iOS 11 or better
- A smartphone or tablet using Android™ version 6.0 or better

Depending on your prescription drug plan, some in-network retail pharmacies can fill prescriptions for specialty drugs. Call your pharmacy to see if your prescription is for a specialty drug and is available there. See the *Specialty pharmacies* section for more information about specialty drugs.

Your health savings options

Your flexible spending account

Your health plan combines a quality Blue Cross health care plan with a health care flexible spending account (FSA). This allows you to save money, pretax, to pay for qualified medical expenses.

How it works

- You may contribute to your health care FSA.
- Your contributions will be automatically deducted, pretax, from your paycheck.
- Money in the health care FSA is used to reimburse you for qualified medical expenses.
- Your employer may choose to offer a grace period instead of the carryover option. A grace period gives you extra time to incur expenses and request reimbursement after the end of the health plan year. Once the grace period ends, any remaining balance from the prior year will be forfeited.

Key advantages

- Your contributions aren't taxed.
- You determine how to spend the money in your FSA.
- Your employer may choose to offer you a debit card to access money in your FSA.

What is a qualified expense?

It’s an expense paid for health care as described in Section 213(d) of the Internal Revenue Code. This can include medical services that may not be paid for by your health plan, certain prescriptions, some over-the-counter drugs, long-term care insurance, and dental and vision care. Ask your employer for a list of qualified medical expenses eligible for payment by your FSA.

Understanding your claims

We want to limit the number of forms you need to fill out. Most doctors file claims electronically after your visits. Many activities, such as updating your health plan information, can be done online or with a call to our Customer Service department.

Your explanation of benefits statement

Find it online

Most of the forms you'll need to manage your Blue Cross benefits are available at **bcbsm.com**. Sign in to your online account and click the *Forms* tab at the top of the page.

When a claim is filed, you'll receive an explanation of benefits statement that shows medical services we pay, as well as any out-of-pocket costs you owe.

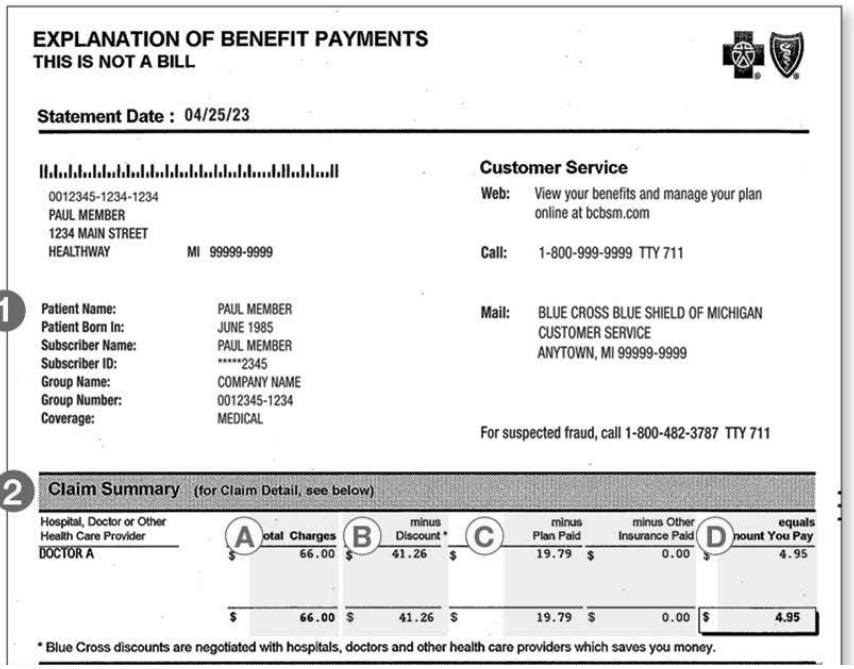
Your statement can be sent by mail or viewed online by logging in to your account at **bcbsm.com** or our mobile app. You can view a history of your doctor visits, services received and how much we paid and more. Your statements are available online for five years.

A quick guide to your explanation of benefits statement

Your explanation of benefits, or EOB, statement shows you the costs associated with the medical care you've received. When a claim is filed under your benefit plan, you'll receive an EOB showing what was billed, any Blue Cross discounts, what we paid and what you pay.

EOB Statement Details

1. This identifies who this EOB statement is for.
2. Summarizes claims by doctor, hospital, or other health care provider as follows:
   - (A) This represents the amount submitted to Blue Cross on the claim.
   - (B) What you saved by being a Blue Cross member.
   - (C) What we paid and amounts your other insurance(s) paid.
   - (D) What you pay. You may have already paid or may still owe this amount. You should never be asked to pay more than this amount.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Statement Date : 04/25/23

0012345-1234-1234
PAUL MEMBER
1234 MAIN STREET
HEALTHWAY MI 99999-9999

Customer Service
Web: View your benefits and manage your plan online at bcbsm.com
Call: 1-800-999-9999 TTY 711
Mail: BLUE CROSS BLUE SHIELD OF MICHIGAN
CUSTOMER SERVICE
ANYTOWN, MI 99999-9999

1
Patient Name: PAUL MEMBER
Patient Born In: JUNE 1985
Subscriber Name: PAUL MEMBER
Subscriber ID: *****2345
Group Name: COMPANY NAME
Group Number: 0012345-1234
Coverage: MEDICAL

For suspected fraud, call 1-800-482-3787 TTY 711

2 **Claim Summary** (for Claim Detail, see below)

Hospital, Doctor or Other Health Care Provider	A otal Charges	B minus Discount *	C minus Plan Paid	minus Other Insurance Paid	D equals nount You Pay
DOCTOR A	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95
	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95

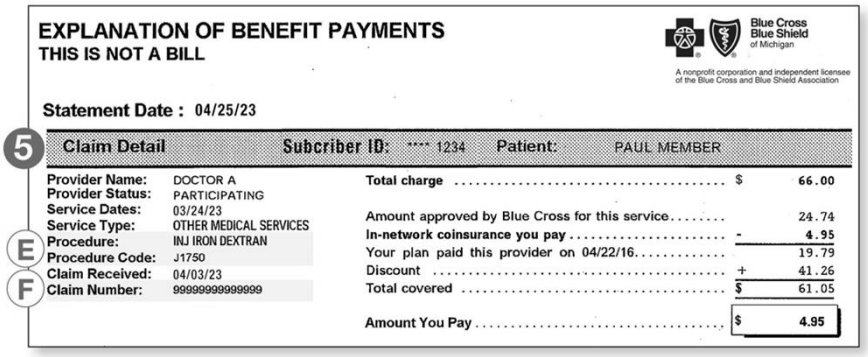
* Blue Cross discounts are negotiated with hospitals, doctors and other health care providers which saves you money.

5 This section shows detailed information about each claim we processed.

It provides additional detail about the types of cost sharing applied to the claim. The sum of all claims in this section for the same provider should match the numbers in the Claim Summary section.

E Information your provider puts on the claim to identify the medical service you received.

F The unique number Blue Cross assigns to a claim. You can reference this number if you need to call us about this claim.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

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

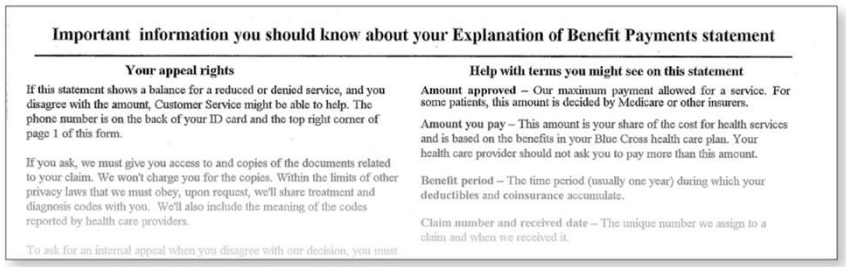
Statement Date : 04/25/23

5 **Claim Detail** **Subcriber ID:** **** 1234 **Patient:** PAUL MEMBER

Provider Name:	DOCTOR A
Provider Status:	PARTICIPATING
Service Dates:	03/24/23
Service Type:	OTHER MEDICAL SERVICES
E **Procedure:**	INJ IRON DEXTRAN
Procedure Code:	J1750
Claim Received:	04/03/23
F **Claim Number:**	99999999999999

Total charge	$	66.00
Amount approved by Blue Cross for this service		24.74
In-network coinsurance you pay	-	4.95
Your plan paid this provider on 04/22/16		19.79
Discount	+	41.26
Total covered	$	61.05
Amount You Pay	$	4.95

Page 2 of your statement shows your appeal rights and what you can do if you disagree with any of the benefit decisions made for a claim. You can also find definitions for terms used on the statement.



Important information you should know about your Explanation of Benefit Payments statement

Your appeal rights

If this statement shows a balance for a reduced or denied service, and you disagree with the amount, Customer Service might be able to help. The phone number is on the back of your ID card and the top right corner of page 1 of this form.

If you ask, we must give you access to and copies of the documents related to your claim. We won't charge you for the copies. Within the limits of other privacy laws that we must obey, upon request, we'll share treatment and diagnosis codes with you. We'll also include the meaning of the codes reported by health care providers.

To ask for an internal appeal when you disagree with our decision, you must

Help with terms you might see on this statement

Amount approved – Our maximum payment allowed for a service. For some patients, this amount is decided by Medicare or other insurers.

Amount you pay – This amount is your share of the cost for health services and is based on the benefits in your Blue Cross health care plan. Your health care provider should not ask you to pay more than this amount.

Benefit period – The time period (usually one year) during which your deductibles and coinsurance accumulate.

Claim number and received date – The unique number we assign to a claim and when we received it.

Thank you for taking the time to become familiar with your Explanation of Benefits statement. If you have questions, call the number on the front of your statement.

Added Blue Cross value

Blue Cross Health & Well-Being℠

Blue Cross Health & Well-Being offers online resources, powered by WebMD®, that can help you get and stay healthy.

- **Health assessment:** You can take an easy lifestyle and health questionnaire that gives you a picture of your current health and health risks.
- **Digital Health Assistant℠:** Based on your health assessment, you'll receive recommendations for digital coaching programs that can help you make big changes in your health by setting and achieving small goals.
- **Helpful online resources:** Blue Cross Health & Well-Being online resources provide helpful information. You can:
  - Read health articles and watch videos on hundreds of topics
  - Research health conditions and procedures
  - Check symptoms and learn about medications
  - Sync fitness and medical devices and apps to keep information in one convenient place
  - Listen to short podcasts about a wide variety of topics that support emotional well-being

Find it online

Your Blue Cross coverage comes with free well-being programs, including a health assessment, digital coaching programs and discounts.

To get connected, go to **bcbsm.com** and click *Login*. Click *Programs & Services,* click on *Wellness*, then click on *Go to WebMD,* to go to the Blue Cross Health & Well-Being site. If it's your first time, you'll need to register.

Your well-being programs with Blue Cross also include:

Tobacco Coaching: This is a 12-week coaching and support program for members who are ready to set a quit date within 30 days. It includes five calls from a health coach scheduled at a time that works for you. If you need extra support, you have unlimited access to call your health coach any time. There is no additional cost to participate in this program. Call WebMD at **1-855-326-5102** to determine your eligibility and schedule your first call.

Blue Cross Virtual Well-Being℠: Includes live, 30-minute, interactive webinars on Thursdays at noon Eastern time focused on engaging and inspiring people to enhance their overall well-being. Every webinar includes a science-based discussion of well-being topics such as menopause, functional fitness and learning to respond, not react.

The Drop 5 Virtual Weight-Loss Community is part of the Thursday webinar. The community is comprised of people trying to lose weight in five-pound increments. Each week, participants interact live and are asked to share their scale and nonscale victories.

In addition to the webinars, guided meditations are presented live each Wednesday. Visit **bluecrossvirtualwellbeing.com** to register for upcoming webinars and meditations or to view past sessions on demand.

24-Hour Nurse Line: Registered nurses are available to answer your questions 24 hours a day, seven days a week.

Engagement Center: Specialists can answer all your well-being services questions at **1-800-775-BLUE (2583)** Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and well-being services.

Member discounts with Blue365®

Save money and live healthier with Blue365

Blue Cross members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

Member discounts with Blue365 offers exclusive deals on:

- **Fitness and wellness**: Fitness gear and gym memberships
- **Healthy eating**: Meal delivery services and weight-loss programs
- **Lifestyle**: Travel and recreation
- **Personal care**: LASIK and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today. You can view a full list of discount offers from your Blue Cross member account.

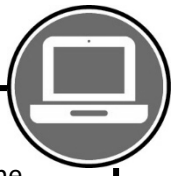
For a full list of discounts, log in or register at **bcbsm.com** and click *Blue365 member discounts* under the programs & services tab. You can also access discounts on the go with the Blue Cross mobile app. Search “BCBSM” on Google Play™ or in the App Store® to download our mobile app.

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365®

Benefits at a glance

The following pages provide detail information about your health plan, including:

- Deductible
- Coinsurance or copayment
- Out-of-pocket maximum
- Preventive care
- Physician office services
- Emergency and urgent care services
- Diagnostic and radiation services
- Maternity services
- Inpatient hospital care
- Surgical care
- Outpatient services and other benefits
- Organ transplantation
- Mental health and substance use disorder services
- Prescription drugs (if applicable to your health plan)
- Dental (if applicable to your plan)
- Vision (if applicable to your plan)



Find it online

You can view your benefits online.

Go to **bcbsm.com**. Sign in to your account and click the *My Coverage* tab at the top of the screen.

You can also check your benefits on the Blue Cross mobile app.

Blue Cross Blue Shield of Michigan

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MICHIGAN STATE UNIVERSITY
Group # 007000468
Community Blue PPO℠ ASC
Effective Date: January 2024
Benefits-at-a-glance

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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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

Benefits	In-network	Out-of-network
Deductible	$100 for one member, $200 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations • $20 copay for medical online visits • $20 copay for chiropractic and osteopathic manipulative therapy • $20 copay for outpatient physical, speech and occupational therapy • $50 copay for emergency room visits • $25 copay for urgent care visits	• $50 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing care • 10%, 20% or 50% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	None	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year
Annual out-of-pocket maximums - applies to in-network deductibles, flat dollar copays and coinsurance amounts for all covered services - but **does not** apply to out-of-network deductible, copays and cost-sharing amounts for prescription drugs, if applicable.	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year	Not Applicable
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/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered

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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. 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.

Benefits	In-network	Out-of-network
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	Not covered
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 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	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% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
	One per member per calendar year	
Flu vaccines	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$20 copay per office visit	80% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$20 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	$20 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	$25 copay per urgent care visit	80% after out-of-network deductible

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) $250 copay per vist for non-medical emergencies	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% (no deductible or copay/coinsurance) for laboratory services 100% after in-network deductible for pathology services	100% (no deductible or copay/coinsurance) for laboratory services 80% after out-of-network deductible for pathology services
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 or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

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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. 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.

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.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% 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	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	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 • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 60 visits per member per calendar year	
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	100% after in-network deductible	100% 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	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	100% after in-network deductible	Not covered

Elective abortions **Note:** Limits elective abortion procedures to one procedure every 24 months	100% after in-network deductible	80% after out-of-network deductible
Weight reduction surgical procedures	90% after in-network deductible	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$20 copay per online visit	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% 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

Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	$20 copay per visit	$20 copay per visit

Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% 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 an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	$20 copay per visit	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
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 an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Approved infertility services - including eligibe testing and diagnostic procedures. **Note:** Assisted reproductive technigues are not covered.	50% after in-network deductible	50% after out-of-network deductible
Prescription drugs	Not covered	Not covered

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