EDWARD W SPARROW HOSPITAL
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Effective Date: 01/01/2020

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.

Provider Networks - Your health care benefits include three provider networks

- **First provider network:** Edward W. Sparrow Hospital, Clinton Memorial Hospital, Carson City Hospital, Ionia County Memorial Hospital. Members will experience the least out-of-pocket costs when facility services are provided at one of these providers. Please refer to the ASC PLAN MODIFICATION (ASC MOD) document under the Certificates and Riders section of the BCBSM portal.
- **Second provider network:** BCBSM PPO In-network Facility and Professional Providers. When services are performed by a provider who is part of BCBSM's PPO In-network, members will experience greater out-of-pocket costs.
- **Third provider network:** Out-of-network Facility and Professional Providers. Members are subject to the greatest out-of-pocket expenses when treatment is received from out-of-network providers without an authorized referral or in absence of an emergency situation.

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

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

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

Note: 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
Deductibles	$100 for one member, $200 for a family (when two or more members are covered under your contract) each calendar year	
Flat-dollar copays	• $15 copay for select office visits • $15 copay for medical online visits	• $15 copay for select office visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services **Note:** You are responsible for an **additional** 20% of approved amount for covered services when you go to an out-of-network provider. (This amount is in addition to applicable CMM deductible, copay and coinsurance amounts.)
Annual out-of-pocket maximums -applies to percent copays for all covered services - including mental health and substance use disorder services - but does not apply to fixed dollar copays and private duty nursing percent copays, if applicable	$1,100 for one member, $1,200 for a family (when two or more members are covered under your contract) each calendar year	
		Note: The **additional** 20% out-of-network coinsurance for covered services from an out-of-network provider is limited to $1,000 for all covered family members each calendar year. (This amount does not count toward the annual out-of-pocket maximum.)
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance

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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
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Pap smear screening-laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after deductible **plus** an additional 20% out-of-network coinsurance
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after deductible **plus** an additional 20% out-of-network coinsurance
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	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
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)	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) **plus** an additional 20% out-of-network coinsurance
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 deductible **plus** an additional 20% out-of-network coinsurance
	One per member per calendar year	

Benefits	In-network	Out-of-network
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 deductible **plus** an additional 20% out-of-network coinsurance
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits	$15 copay per office visit	$15 copay per office visit **plus** an additional 20% out-of-network coinsurance
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$15 copay per visit	Not covered
Outpatient and home medical care visits	$15 copay per visit	$15 copay per office visit **plus** an additional 20% out-of-network coinsurance
Office consultations	$15 copay per office consultation	$15 copay per office visit **plus** an additional 20% out-of-network coinsurance

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	80% after deductible	80% after deductible
Ambulance services-must be medically necessary	80% after deductible	80% after deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Diagnostic tests and x-rays	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Therapeutic radiology	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

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 deductible **plus** an additional 20% out-of-network coinsurance
Postnatal care	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

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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
Delivery and nursery care	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

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.	80% after deductible Unlimited days	80% after deductible **plus** an additional 20% out-of-network coinsurance
Inpatient consultations	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Chemotherapy	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care-must be in a **participating** skilled nursing facility	Not covered	Not covered
Hospice care	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)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after deductible	80% after deductible
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	80% after deductible	80% after 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	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after deductible **plus** an additional 20% out-of-network coinsurance
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	Not covered	Not covered

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Benefits	In-network	Out-of-network
Voluntary abortions	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

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)	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Kidney, cornea and skin transplants	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
	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	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Outpatient mental health care • Facility and clinic	80% after deductible	80% after deductible, in participating facilities **only**
Online visits **Note:** Online visits by a vendor are not covered.	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
• Physician's office	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Outpatient substance use disorder treatment-in approved facilities **only**	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance(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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, 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.	80% after deductible	80% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
Other covered services, including mental health services, for autism spectrum disorder	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance

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 cost-sharing when rendered by a participating provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after deductible **plus** an additional 20% out-of-network coinsurance
Allergy testing and therapy	$15 copay per visit	80% after deductible **plus** an additional 20% out-of-network coinsurance
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance
	Limited to a **combined** 38-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy- provided for rehabilitation	80% after deductible	80% after deductible **plus** an additional 20% out-of-network coinsurance **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment **Note:** DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after deductible	80% after deductible
Prosthetic and orthotic appliances	80% after deductible	80% after deductible
Private duty nursing	50% after deductible	50% after deductible

BCBSM Preferred RX Program

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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network 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 Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Copay	You pay 20% of the approved amount, but not less than $5 or more than $100	You pay 20% of the approved amount, but not less than $5 or more than $100 plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 90 day supply:** • You pay 20% of the approved amount, but not less than $5 or more than $100	Not covered

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount

Benefits	In-network pharmacy	Out-of-network pharmacy
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
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 Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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Features of your prescription drug plan

Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy, along with the preferred medications.** If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Clinical Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.