Lake Superior State
Division 0006 - Faculty
Effective Date: On or after January, 2019
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 the Carrier's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. 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 the Carrier 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 ID card and providing the procedure code. Your provider can also provide this information upon request.

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

Benefits	In-network	Out-of-network
Deductibles **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **HRA $250 for one member, $500 for the family (when two or more members are covered)**	$10,000 for one member, $20,000 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 **HRA $500 for one member, $1,000 for the family (when two or more members are covered)**
Flat-dollar copays	• $40 copay for office visits & office consultations with a non-specialist or specialist provider **HRA $30** • $40 copay for medical online visits **HRA $5** • $40 copay for chiropractic and osteopathic manipulative therapy **HRA $30** • $250 copay for emergency room visits **HRA $150** • $40 copay per UC visit **HRA $30**	$250 copay for emergency room visits **HRA $150**
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) **HRA Zero Coinsurance**	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services **HRA $1,000 for one member, $2,000 for the family (when two or more members are covered)**
Annual coinsurance maximums	None	None
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year **HRA $750 for one member, $1,500 for the family (when two or more members are covered)**	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **HRA $1,500 for one member, $3,000 for the family (when two or more members are covered)**
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

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.	Not Covered
Pap smear screening -laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
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)	60% 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 the Carrier 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 One per member per calendar year	60% 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.
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 One per member per calendar year	60% after out-of-network deductible

Physician office services

Benefits	In-network	Out-of-network
Office visits-must be medically necessary	• $40 copay per office visit with a non-specialist provider **HRA $30** • $40 copay per office visit with a specialist provider **HRA $30**	60% after out-of-network deductible
Outpatient and home medical care visits-must be medically necessary	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Office consultations-must be medically necessary	• $40 copay per office consultation with a non-specialist provider **HRA $30** • $40 copay per office consultation with a specialist provider **HRA $30**	60% after out-of-network deductible
Online visits – must be medically necessary **Note:** Online visits by a non-Carrier selected vendor are not covered.	$40 copay for online visits **HRA $5** **$35 difference will be refunded automatically by check to the member**	60% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	$40 copay per urgent care visit **HRA $30**	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (waived if admitted or for an accidental injury) **HRA $150**	$250 copay per visit (copay waived if admitted or for an accidental injury) **HRA $150**
Ambulance services-must be medically necessary	80% HRA 100% after in-network deductible	80% HRA 100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% HRA 100% after in-network deductible	60% 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)	60% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% **HRA 100%** after in-network deductible	60% after out-of-network deductible

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% HRA 100% after in-network deductible	60% after out-of-network deductible Unlimited days
Inpatient consultations	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% HRA 100% after in-network deductible	60% 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	80% HRA 100% after in-network deductible	80% HRA 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	80% HRA 100% after in-network deductible	80% HRA 100% after in-network 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% HRA 100% after in-network deductible	80% HRA 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	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see "**Preventive care services.**"	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Elective abortions	80% HRA 100% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants-must be in a **designated** facility and coordinated through the Carrier's 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 Carrier's Human Organ Transplant Program (1-800-242-3504)	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note**: The Carrier covers clinical trials in compliance with PPACA.	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% HRA 100% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

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

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% HRA 100% after in-network deductible Unlimited days	60% after out-of-network deductible
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% HRA 100% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: •Facility and clinic **Note**: Online visits by a non-Carrier selected vendor are not covered.	80% HRA 100% after in-network deductible in participating facilities **only**	
• Physician's office	80% HRA 100% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment- in approved facilities **only**	80% HRA 100% after in-network deductible	60% 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 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 Carrier approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% HRA 100% after in-network deductible	80% HRA 100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% HRA 100% after in-network deductible Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	60% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	80% HRA 100% after in-network deductible	60% 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.	• 80% HRA 100% after in-network deductible diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$40 copay per visit HRA $30	60% 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	80% HRA 100% after in-network deductible	60% 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 the Carrier.	80% HRA 100% after in-network deductible	80% HRA 100% after in-network deductible
Prosthetic and orthotic appliances	80% HRA 100% after in-network deductible	80% HRA 100% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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Dental Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance

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Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**
[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Class I services	None (covered at 100%)
Class II services	20%
Class III services	50%
Class IV services	50%
Annual maximum for Class I, II and III services	$1,000 per member
Lifetime maximum for Class IV services	$1,500 per member

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	80% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	80% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	80% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simple extractions	80% of approved amount
Root canal treatment - permanent tooth	80% of approved amount **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	80% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	80% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	80% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months

Benefits	Coverage
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months after original was delivered
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

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Vision Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance

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Essential Vision benefits are provided by Heritage Total Services. Heritage Vision Plans is an independent company providing vision benefit services for Blues members. To find a Heritage Total Services network provider, call **1-800-252-2053** or visit Heritage Vision Plans online at **heritagevisionplans.com.**

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	Network doctor	Non-network provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	Network doctor	Non-network 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.	$5 copay	Reimbursement up to $35 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	Network doctor	Non-network provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $65 less $7.50 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact lenses

Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to approved amount less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months when services are rendered by a Heritage network provider.	