Wexford Missaukee ISD- Base Plan B

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 CARRIER's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable CARRIER 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 CARRIER except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your CARRIER ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – CARRIER will pay for FDA-approved specialty pharmaceuticals that meet CARRIER's medical policy criteria for treatment of the condition. The prescribing physician **must** contact CARRIER to request preauthorization of the drugs. If preauthorization is not sought, CARRIER 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. CARRIER determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

	In-network	**Out-of-network ***
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	$5,000 for one member $10,000 for the family (when two or more members are covered under your contract) each calendar year **HRA to $500/$1,000** **Note:** Deductible may be waived for covered services performed in an in-network physician's office.	$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.
Flat-dollar copays	• $40 copay for office visits and Chiropractic Services **HRA to $20** • $250 copay for emergency room visit	$250 copay for emergency room visit
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 30% of approved amount for mental health care and substance abuse treatment • 30% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 30% Coinsurance **HRA to $1,500/$3,000**	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance abuse treatment • 40% of approved amount for most other covered services

	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member $12,700 for two or more members each calendar year	$12,700 for one member $25,400 for two or more members each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	
Preventive care services		
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), 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) • 6 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 CARRIER that are in compliance with the provisions of the Patient Protection and	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

	In-network	Out-of-network *
Physician office services		
Office visits – must be medically necessary	$40 copay per office visit **HRA to $20**	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	70% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	$40 copay per office visit **HRA to $20**	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$40 copay per office visit **HRA to $20**	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$250 copay per visit (copay waived if admitted or for an accidental injury)	$250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	70% after in-network deductible	70% after in-network deductible
Diagnostic services		
Laboratory and pathology services	70% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	70% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	70% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
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	70% after in-network deductible	60% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	70% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	70% after in-network deductible	60% after out-of-network deductible
Chemotherapy	70% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	70% after in-network deductible	70% 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	70% after in-network deductible	70% 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	70% after in-network deductible	70% after in-network deductible

	In-network	Out-of-network *
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	70% 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.**"	70% after in-network deductible	60% after out-of-network deductible
Elective abortions	Not covered	Not covered
Human organ transplants		
Specified human organ transplants – must be in a **designated** facility and coordinated through the CARRIER Human Organ Transplant Program (1-800-	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 Human Organ Transplant Program (1-800-242-3504)	70% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** CARRIER covers clinical trials in compliance with PPACA.	70% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	70% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by CARRIER to be comparable to an office visit. When a mental health and substance abuse service is considered by CARRIER to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will have no in-network deductible. You will be responsible for the flat-dollar member copay that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and **inpatient** substance abuse treatment	70% after in-network deductible Unlimited days	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	70% after in-network deductible **If Processed as Office Visit, HRA to $0**	70% after in-network deductible, in participating facilities **only**
• Physician's office	70% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	70% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

	In-network	Out-of-network *
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 **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. ABA and AAEC services are not available outside of Michigan.	70% after in-network deductible	70% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	70% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is limited to the same annual **combined** limit as for physical, speech and occupational therapy for other diagnoses	
Other covered services, including mental health services, for autism spectrum disorder	70% after in-network deductible	60% after out-of-network deductible
Other covered services		
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.	70% after in-network deductible for 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 office visit **HRA to $20**	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	70% 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 (visits are **combined** with therapies for autism spectrum disorder)	
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 CARRIER.	70% after in-network deductible	70% after in-network deductible
Prosthetic and orthotic appliances	70% after in-network deductible	70% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Prescription drugs	$20/$60/$50% 2x MOPD	**Generic**: $20 co-pay plus 25% of CARRIER approved amount for the drug. **Brand**: $60 co-pay plus 25% co-insurance of CARRIER approved amount for the drug. **3rd Tier:** 50% co-pay plus 25% co-insurance of CARRIER approved amount for the drug

LG Prescription Drug Coverage Triple-Tier Copay, Open Formulary Benefits-at-a-Glance

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Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, 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. Walgreens Specialty Pharmacy 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 Carrier's members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that CARRIER 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. CARRIER reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, 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 CARRIER'S's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

		90-day retail network pharmacy	*** In-network mail order provider**	**In-network pharmacy** (not part of the 90-day retail network)	**Out-of-network pharmacy**
Tier 1 – Generic or select prescribed over-the-counter drugs	1 to 30-day period	$20 copay	$20 copay	$20 copay	$20 copay ***plus*** an additional 25% of approved amount for the drug
	31 to 83-day period	No coverage	$40 copay	No coverage	No coverage
	84 to 90-day period	$40 copay	$40 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	$60 copay	$60 copay	$60 copay	$60 copay ***plus*** an additional 25% of approved amount for the drug
	31 to 83-day period	No coverage	$120 copay	No coverage	No coverage
	84 to 90-day period	$120 copay	$120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by Carrier 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 Carrier will approve use of other drugs.

*** Carrier** will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	$80 or 50% of the approved amount (whichever is greater), but no more than $100	$80 or 50% of the approved amount (whichever is greater), but no more than $100	$80 or 50% of the approved amount (whichever is greater), but no more than $100	$80 or 50% of the approved amount (whichever is greater), but no more than $100 ***plus*** an additional 25% of CARRIER approved amount for the drug
	31 to 83-day period	No coverage	$160 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	84 to 90-day period	$160 or 50% of the approved amount (whichever is greater), but no more than $200	$160 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage

Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by CARRIER	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements, and vitamins	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved **brand name** prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

***** Carrier will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

CARRIER Custom Formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the CARRIER Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from CARRIER **before** select prescription drugs (drugs identified by CARRIER as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a 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 CARRIER 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 nonpreferred brand-name drug with a generic equivalent from CARRIER 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.
Drug interchange and generic copay waiver	CARRIER's drug interchange and generic copay 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. In select cases CARRIER may waive the initial copay after your prescription has been rewritten. CARRIER will notify you if you are eligible for a
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.