LAKE SUPERIOR STATE UNIVERSITY
007004176-0006 - Faculty with Seamless HRA
Community Blue PPO℠ LG
Effective Date: On or after January 2023
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.

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.

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

Benefits	In-network	Out-of-network
Deductibles HRA In-Network Deductible Single $250 Family $500 HRA Out-of-Network Deductible Single $500 Family $1,000	$5,000 for one member, $10,000 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.	$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 office consultations HRA copay $30 • $40 copay for medical online visits HRA copay $5 • $40 copay for chiropractic and HRA copay $30 osteopathic manipulative therapy • $250 copay for emergency room visits HRA copay $150 • $40 copay for urgent care visits HRA copay $30	• $250 copay for emergency room visits HRA copay $150
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met. HRA Coinsurance: 0% HRA Out-of-Network Coinsurance Single $1,000 Family $2,000	• 50% of approved amount for private duty nursing care HRA: Not Covered • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
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 HRA In-Network Max Single $750 Family $1,500 HRA Out-of-Network Max Single $1,500 Family $3,000	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) 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

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

ADM HCR-RXOC;ADM PLANYR JAN;CB LG;CB-EA-1 LG;CB-ET $250 LG;CB-MTC $40 LG;CB-OV $40 LG;CBC 20%-IN LG;CBC 40%-ON LG;CBD $10K-ON LG;CBD $5000-IN LG;CBOPMIN 6350 LG;CBOPMON12.7K LG;RxCO-AF LG

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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 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.	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.
	One per member per calendar year	

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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.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$40 copay per office visit HRA copay $30	60% after out-of-network deductible
Online visits - must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered	$40 copay per online visit HRA copay $5 $35 will be reimbursed automatically by check to member	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$40 copay per office consultation HRA copay $30	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$40 copay per urgent care visit HRA copay $30	60% after out-of-network deductible

Emergency medical care

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

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible 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

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Benefits	In-network	Out-of-network
Postnatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible 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	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Note: Nonemergency services must be rendered in a **participating** hospital.		
Inpatient consultations	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible 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 Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible 100% after in-network deductible	80% after in-network deductible 100% after in-network deductible
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% after in-network deductible 100% after in-network deductible	80% after in-network deductible 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% after in-network deductible 100% after in-network deductible	80% 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	80% after in-network deductible 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

Benefits	In-network	Out-of-network
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Elective abortions	80% after in-network deductible 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 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 in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible 100% after in-network deductible	60% 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	80% after in-network deductible 100% after in-network deductible	60% 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	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible 100% after in-network deductible	80% after in-network deductible in participating facilities **only** 100% after in-network deductible
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	$40 copay per online visit HRA copay $5 $35 will be reimbursed automatically by check to member	60% after out-of-network deductible
• Physician's office	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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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 in-network deductible 100% after in-network deductible	80% after in-network deductible 100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible 100% after in-network deductible	60% 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	80% after in-network deductible 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% after in-network deductible for diabetes medical supplies; 100% after in-network deductible • 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 copay $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 - when provided for rehabilitation	80% after in-network deductible 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:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **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 100% after in-network deductible	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible 100% after in-network deductible	60% after out-of-network deductible
Private duty nursing care HRA: Not Covered In or Out-Of Network	50% after in-network deductible	50% after in-network deductible

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► Pharmacy Network

Chains Available Nationwide

CVS Pharmacy
Meijer Pharmacy
Target Pharmacy
Walgreens Pharmacy
Walmart Pharmacy

ARORx's participating pharmacy network includes more than 67,000 retail pharmacies, including regional and national chains, as well as independently owned pharmacies. To locate a pharmacy near you, log on to members.arorx.com and access our online pharmacy locator. You may also contact ARORx Member Services at 833-306-4092 and speak with a Patient Advocate to assist in finding a pharmacy near you or email ARORx at Rx@arorx.com.

Contact Us

For questions concerning your prescription drug program call ARORx at:

833-306-4092

or email ARORx at RX@arorx.com

Patient Advocates are available for routine inquiries Monday through Friday from 8am to 5pm (Eastern Time) and for emergency services 24/7. No one can predict an emergency and no emergency should have to wait.
ARORx 24/7 patient advocates are there when you need help.

Your network pharmacist can also call ARORx for specific questions about your prescriptions.

For questions regarding your mail order prescription call ARORx at:

833-306-4092

or email ARORx at RX@arorx.com.

Member Services is available Monday through Friday from 8AM to 5PM (Eastern Time) and for emergency services 24/7.

***Note: To order refills, call 800-687-0707**
Monday through Friday from 8AM to 5PM (Eastern Time)
or log-on to members.arorx.com

► ARO Rx

Prescription Drug Program
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►About Your Medications

Retail Medications

Medications dispensed at an ARORx participating retail pharmacy are limited to a 90-day supply. Medications dispensed between 31-83 days are excluded.

Mail Order Medications

MXP Pharmacy offers a convenient, cost effective way to order prescribed long-term medications for delivery to your home. Medications obtained through mail order are limited to a 90-day supply. Medications dispensed between 31-83 days are excluded. To maximize your savings, please ask your doctor to write, submit electronically, or fax your prescription for a 90-day supply with refills up to one year. Once MXP Pharmacy has your prescription, refills can easily be obtained. To get started, please use one of the following options:

1) Go Online - Create an ARORx member web portal account at members.arorx.com. After you have successfully created an account, select the "Sign-Up for Mail Order" feature.
2) By Phone - Call (800) 687-0707

Specialty Medications

Please call (833) 306-4092 or email ARORx at RX@arorx.com for payment assistance.

Refills

If your physician has authorized refills, you may refill your prescription once 75% of the prescription has been used.

Formulary

The ARORx Formulary will be utilized with your drug program. The formulary is a list of medications to be used as a guide for physicians when prescribing. For the comprehensive formulary, please create a member portal account by visiting our website at members.arorx.com*

How Your Formulary Works

Generic - Generic medications contain the same active ingredients as their corresponding brand-name medications. The generics on this formulary are listed in lower case letters.

Preferred - Brand-name medications listed on the formulary in all capital letters.

Non-Preferred - Brand-name medications not listed on the formulary or listed as non-preferred for example purposes.

* Not all drugs listed on the formulary are covered by all prescription drug benefit programs: check your benefit materials for the specific drugs that are covered and those which are excluded.

►Prescription Copay Amounts

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TIER	RETAIL COPAY 30 Day Supply	MAIL ORDER 90 Day Supply
Generic	$10.00	$10.00
Preferred Brand*	$20.00	$20.00
Non-Preferred Brand*	$20.00	$20.00

* If a patient or doctor requests a brand name drug when a generic equivalent exists, the patient will pay the difference between the brand and generic medication in addition to the applicable brand copay.

†Contraceptives and certain preventive medications are covered at $0 copay, as required by the Affordable Care Act.

►About Your Benefits Coverage

Covered Drugs, Limitations and Exclusions

Most prescription drugs that require a "written" prescription by a licensed physician are covered. Anti-wrinkle agents (e.g. Renova), cosmetic hair removal products (e.g. Vaniqa), hair growth stimulants, non-legend drugs other than insulin, therapeutic devices or appliances, and other non-medicinal substances, regardless of intended use, except those listed above, and charges for the administration or injection of any drug are generally not covered under your drug benefit. In addition, certain restrictions, quantity limits or prior authorization requirements may apply.* To obtain additional information about these restrictions, or for more coverage information, contact your HR Department or an ARORx Patient Advocate.

***This is not intended to be a full explanation of benefits, limitations, or exclusions. For more information, please review your benefit documents.**

Using A Non-Participating Pharmacy

This program requires eligible members to use an ARORx participating pharmacy (refer to the pharmacy network list). When an out-of-network pharmacy is used, you may be responsible for paying more than just the required copay. Prescriptions purchased at "non-participating pharmacies" are covered only in emergency situations, for example, you're out-of-town and unable to locate an ARORx participating pharmacy or you need an emergency prescription filled late at night. You will need to pay 100% of the prescription drug cost and obtain a receipt. Then you must submit a paper claim along with the receipt for reimbursement to ARORx. You can request this form from your employee benefits office or ARORx. You will be reimbursed the network-discounted rate minus your copay.