



A MEMBER COMPANY OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

SCHOLASTIC SOLUTIONS LLC

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Community Blue PPOSM LG

Effective Date: On or after February 2017

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/coinsurance. For a complete description of benefits please see the applicable BCBSM 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 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.

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

Benefits	In-network	Out-of-network
Deductibles	None	\$5,000 for one member, \$10,000 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, if applicable
Flat-dollar copays	<ul style="list-style-type: none"> \$40 copay for office visits and office consultations \$40 copay for online visits \$40 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits \$40 copay for urgent care visits 	<ul style="list-style-type: none"> \$150 copay for emergency room visits
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 50% of approved amount for mental health care and substance abuse treatment 50% of approved amount for most other covered services
Note: Coinsurance amounts apply once the deductible has been met.		
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	\$600 for one member, \$1,200 for the family (when two or more members are covered under your contract) each calendar year	\$11,500 for one member, \$23,000 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
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)	50% after out-of-network deductible

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Benefits	In-network	Out-of-network
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)	50% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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	50% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
		One per member per calendar year
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance), for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	50% 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	50% after out-of-network deductible
Online visits - must be medically necessary	\$40 copay per online visit	50% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Office consultations - must be medically necessary	\$40 copay per office consultation	50% after out-of-network deductible
Urgent care visits - must be medically necessary	\$40 copay per urgent care visit	50% after out-of-network deductible

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Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services		
Benefits	In-network	Out-of-network
Laboratory and pathology services	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Diagnostic tests and x-rays	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Therapeutic radiology	100% (no deductible or copay/coinsurance)	50% 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)	50% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Delivery and nursery care	100% (no deductible or copay/coinsurance)	50% 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	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Chemotherapy	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible

Alternatives to hospital care		
Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	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)	

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Benefits	In-network	Out-of-network
Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Surgical services		
Benefits	In-network	Out-of-network
Surgery - Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Voluntary sterilization for males	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Note: For voluntary sterilizations for females, see "Preventive care services."		
Elective Abortions	Not covered	Not covered

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Specified oncology clinical trials	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM 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 abuse treatment	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria 	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: • Facility and clinic	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) in participating facilities only
• Physician's office	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	100% (no deductible or copay/coinsurance)	50% 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	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
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.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% (no deductible or copay/coinsurance) Physical, speech and occupational therapy with an autism diagnosis is unlimited	50% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	50% 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.	<ul style="list-style-type: none"> 100% (no deductible or copay/coinsurance) for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training 	50% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per visit Limited to a combined 24-visit maximum per member per calendar year	50% after out-of-network deductible
Outpatient physical, speech and occupational therapy - when provided for rehabilitation	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 60-visit maximum per member per calendar year
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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Benefits	In-network	Out-of-network
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)

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