Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

CATA (Capital Area Transportation Authority)
Group Number: 71468 Package Code(s): 040, 041
Section Code(s): 1000, 1005, 1100, 1105
PPO - HDHP PPO Plan, Dental, Vision, RX2
Effective Date: 03/01/2019
Benefits-at-a-glance

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Note: A list of services that require approval before they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services.**

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

Benefits	In-Network	Out-of-Network
Deductibles - per benefit period The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,350 per member $2,700 per family	$2,700 per member $5,400 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$1,350 per member $2,700 per family Includes Deductible, Coinsurance and Copays	$5,400 per member $10,800 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per benefit period	Covered - 100%	Covered - 80% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 80% after deductible
Annual Gynecological Exam - two per benefit period, in addition to health maintenance exam	Covered - 100%	Covered - 80% after deductible
Pap Smear Screening - one per benefit period	Covered - 100%	Covered - 80% after deductible

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Benefits	In-Network	Out-of-Network
Mammography Screening - one per benefit period includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per benefit period	Covered - 100%	Covered - 80% after deductible
Endoscopic Exams - one per benefit period	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 35 months • 2 visits, 36 months through 47 months	Covered - 100%	Covered - 80% after deductible
Visits beyond 47 months are limited to one per member per benefit period under the health maintenance exam benefit		
Immunizations - pediatric and adult	Covered - 100%	Covered - 80% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible; copay waived if admitted	Covered - 100% after deductible; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after deductible	Covered - 100% after deductible
Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Covered - 80% after deductible
Postnatal Care Visits	Covered - 100% after deductible	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 100 days per benefit period	Covered - 100% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral/Mental Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible

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Blue Cross Blue Shield of Michigan

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CATA (Capital Area Transportation Authority)
Group Number: 71468 Package Code(s): 010
Section Code(s): 1000, 1005, 1100, 1105
PPO - PPO Plan A, RX1, Dental, Vision
Effective Date: 03/01/2019
Benefits-at-a-glance

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

Benefits	In-Network	Out-of-Network
Deductibles - per benefit period	$200 per member $400 two person $600 per family	$400 per member $800 two person $1,200 per family
Copays • Fixed Dollar Copays	$20 copay for : • Chiropractic spinal manipulations • Primary Care Physician (PCP) office visits $30 copay for : • Specialist office visits $45 copay for : • Urgent care services $100 copay for : • Facility medical emergency	$40 copay for : • Chiropractic spinal manipulations • Primary Care Physician (PCP) office visits $60 copay for : • Specialist office visits $80 copay for : • Urgent care services $100 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	0%	20% Note: Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$6,600 per member $13,200 two person $13,200 per family Includes Deductible, Coinsurance and Copays	$2,400 per member $4,800 two person $7,200 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

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Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per benefit period	Covered - 100%	Covered - 80% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 80% after deductible
Annual Gynecological Exam - two per benefit period, in addition to health maintenance exam	Covered - 100%	Covered - 80% after deductible
Pap Smear Screening - one per benefit period	Covered - 100%	Covered - 80% after deductible
Mammography Screening - one per benefit period includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per benefit period	Covered - 100%	Covered - 80% after deductible
Endoscopic Exams - one per benefit period	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per benefit period under the health maintenance exam benefit	Covered - 100%	Covered - 80% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 80% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 pcp copay; $30 specialist copay	Covered - 80% after $40 pcp copay; $60 specialist copay
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay; copay waived if admitted	Covered - 100% after $100 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after $100 copay	Covered - 100% after $100 copay
Urgent Care Services	Covered - 100% after $45 copay	Covered - 80% after $80 copay
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 80%

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 100 days per benefit period	Covered - 100% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral/Mental Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 100% after $20 copay	Covered - 80% after deductible

CATA (Capital Area Transportation Authority)
Group Number: 71468 Package Code(s): 040, 041
Section Code(s): 1000, 1005, 1100, 1105
Dental Coverage - Blue Dental PPO Plus
Effective Date: 03/01/2019
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.

Blue Dental PPO network - Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations 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**.
Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
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 Select℠ 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 non-participating 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
Benefit Period	Benefit Period
Deductible	None
Class I services	0%
Class II services	0%
Class III services	0%
Class IV services	50%
Dollar Maximums - Annual Maximum	$1000 per member Class I, II & III services
Lifetime Orthodontic Maximum	$1200 per member

Class I services

Benefits	Coverage
Periodic Oral Exams	Covered - 100%, twice per benefit period
Prophylaxis (Teeth Cleaning)	Covered - 100%, twice per benefit period

Benefits	Coverage
Bitewing X-Rays	Covered - 100%, twice per benefit period
Full-mouth or Panoramic X-Rays	Covered - 100%, once per 36 months
Fluoride Treatment	Covered - 100%, once every 36 months
Space Maintainers	Covered - 100%, once per quadrant per lifetime, up to and including age 18
Palliative Emergency Treatment	Covered - 100%
Sealants	Covered - 100%, once per tooth every 36 months, up to and including age 13

Class II services

Benefits	Coverage
Fillings - permanent teeth	Covered - 100%, once per tooth per surface every 24 months
Fillings - primary teeth	Covered - 100%, once per tooth per surface every 12 months
Root Canal Therapy	Covered - 100%, once per tooth, once every 12 months for teeth with one or more canal
Periodontal Scaling and Root Planing	Covered - 100%, once every 24 months
General Anesthesia or IV Sedation with oral surgery	Covered - 100%
Oral Surgery including extractions	Covered - 100%
Consultations/Evaluations	Covered - 100%, three per benefit period

Class III services

Benefits	Coverage
Removable Dentures - Complete and Partials	Covered - 100%, once per arch every 60 months
Fixed Bridges	Covered - 100%, once per tooth every 60 months age 16 and older
Implants	Covered - 100%, once per tooth per lifetime age 16 and older
Inlays, Onlays and Crowns - permanent teeth	Covered - 100%, once every 60 months
Recementing of Inlays, Onlays, Crowns and Bridges	Covered - 100%, three per benefit period
Occlusal Adjustment	Covered - 100%, up to five times in a 60 month period
Relining or Rebasing of Partials or Dentures	Covered - 100%, once per arch every 36 months
Tissue Conditioning	Covered - 100%
Repair to Existing Partials or Dentures	Covered - 100%

Class IV services - Orthodontic services for dependents up to and including age 19

Benefits	Coverage
Orthodontic Services	Covered - 50%
Cephalometric Films and Oral Facial Photos	Covered - 50%
Habit Breaking Appliances	Covered - 50%
Full-Banding Treatment	Covered - 50%
Minor Tooth Guidance Appliances	Covered - 50%

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CATA (Capital Area Transportation Authority)
Group Number: 71468 Package Code(s): 040, 041
Section Code(s): 1000, 1005, 1100, 1105
Vision Coverage - Blue Signature VSP
Effective Date: 03/01/2019
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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call **1-800-877-7195** or visit VSP's Web site at **www.vsp.com**.

Member's responsibility (copayments)

Benefits	VSP Provider	Out-of-Network Provider
Eye Exam	No Copay	Reimbursement up to $50
Lenses and/or frames	No Copay	Member responsible for difference between approved amount and provider's charge
Medically necessary contact lenses	No Copay	Member responsible for difference between approved amount and provider's charge

Eye exams

Benefits	VSP Provider	Out-of-Network Provider
Covers a 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.	Covered - no copay	Covered - reimbursement up to $50
		One per calendar year

Lenses and frames

Benefits	VSP Provider	Out-of-Network Provider
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - no copay	Covered - reimbursement up to $50 for single vision lens; $75 for bifocal lens; $100 for trifocal lens; $125 for lenticular lens
		Once every 24 months
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered - no copay	Covered - reimbursement up to $70
		Once every 12 months

Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both

Benefits	VSP Provider	Out-of-Network Provider
Elective contact lenses (prescribed, but not medically necessary) may be chosen instead of spectacle lenses and a frame.	Covered - $130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered - $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Once every 24 months	
Therapeutic contact lenses (medically necessary)	Covered - no copay	Covered - reimbursement up to $210
	Once every 24 months	

Benefits	Coverage
Diabetic Supplies	Includes: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit Retail Test Strips and Lancets: 0% after deductible Mail Order Test Strips and Lancets: 0% after deductible

Features of your prescription drug plan

Preferred Therapy Program	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand- name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
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 BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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CATA (Capital Area Transportation Authority)
Group Number: 71468 Package Code(s): 040, 041
Section Code(s): 1000, 1005, 1100, 1105
Prescription Drugs
Effective Date: 03/01/2019
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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$1,350 per individual $2,700 per family
Retail - 30 day supply	0% coinsurance after deductible - Generic and Brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	0% coinsurance after deductible - Generic and Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	0% after deductible Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Not Covered
Impotency Drugs	Not Covered
Infertility Drugs	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 38 visits per benefit period	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 100% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Physical therapy is limited to 60 visits	Covered - 100% after deductible	Covered - 80% after deductible