



Community BlueSM PPO – Plan 1 Benefits-at-a-Glance Delta College

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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 or your summary plan description 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.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Fixed dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits \$50 copay for emergency room visits 	\$50 copay for emergency room visits
Percent copays Note: Copays apply once the deductible has been met.	50% of approved amount for private duty nursing See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays	Not applicable	\$2,000 for one member, \$4,000 for two or more members each calendar year
Lifetime dollar maximum	None	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

* Services from a provider for which there is no Michigan PPO network and services from a non-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.



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> • 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 BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for the first billed colonoscopy (no deductible or copay) Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible
	One per member per calendar year	

Physician office services

Office visits	\$20 copay per office visit	80% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	100% (no deductible or copay)	80% after out-of-network deductible, must be medically necessary
Office consultations	\$20 copay per office visit	80% after out-of-network deductible, must be medically necessary
Urgent care visits	\$20 copay per office visit	80% after out-of-network deductible, must be medically necessary

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In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	100% (no deductible or copay)	100% (no deductible or copay)

Diagnostic services

Laboratory and pathology services	100% (no deductible or copay)	80% after out-of-network deductible
Diagnostic tests and x-rays	100% (no deductible or copay)	80% after out-of-network deductible
Therapeutic radiology	100% (no deductible or copay)	80% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	80% after out-of-network deductible
Delivery and nursery care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	80% 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.	100% (no deductible or copay) Unlimited days	80% after out-of-network deductible
Inpatient consultations	100% (no deductible or copay)	80% after out-of-network deductible
Chemotherapy	100% (no deductible or copay)	80% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	100% (no deductible or copay) Limited to a maximum of 120 days per member per calendar year	100% (no deductible or copay)
Hospice care	100% (no deductible or copay) 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)	100% (no deductible or copay)
Home health care – must be medically necessary and provided by a participating home health care agency	100% (no deductible or copay)	100% (no deductible or copay)
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	100% (no deductible or copay)	100% (no deductible or copay)

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% (no deductible or copay)	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	80% after out-of-network deductible
Voluntary sterilization	100% (no deductible or copay)	80% after out-of-network deductible

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In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	80% after out-of-network deductible
Specified oncology clinical trials	100% (no deductible or copay)	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% (no deductible or copay)	80% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care	100% (no deductible or copay)	80% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	100% (no deductible or copay)	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	100% (no deductible or copay)	100% (no deductible or copay), in participating facilities only
	\$20 copay per office visit	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	100% (no deductible or copay) **	100% (no deductible or copay)

** Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

Other covered services

Outpatient Diabetes Management Program (ODMP)	100% (no deductible or copay)	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	80% after out-of-network deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	\$20 copay per office visit	80% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% (no deductible or copay)	80% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	100% (no deductible or copay)	100% (no deductible or copay)
Prosthetic and orthotic appliances	100% (no deductible or copay)	100% (no deductible or copay)
Private duty nursing	50% (no deductible)	50% (no deductible)

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Blue Preferred[®] Rx Prescription Drug Coverage with \$20 Generic / \$40 Brand Name Fixed Dollar Copay Benefits-at-a-Glance Delta College

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Specialty 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. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many 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 Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM 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).

Network pharmacy

Non-network pharmacy

Member's responsibility (copays)

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber did not write "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic *plus* the applicable copay.

	Network pharmacy	Non-network pharmacy
Generic prescription drugs	\$20 copay	\$20 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.	\$20 copay	\$20 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	\$40 copay 50% for select lifestyle drugs	\$40 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 30 day supply: • \$20 copay for each generic drug • \$40 copay for each brand name drug Copay for a 31 to 90 day supply: • \$40 copay for each generic drug • \$80 copay for each brand name drug	No coverage

Covered services

	Network pharmacy	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	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	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

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Features of your prescription drug plan

<p>Drug interchange and generic copay waiver</p>	<p>Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
<p>Quantity limits</p>	<p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p>
<p>Prescription drug preferred therapy</p>	<p>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 filed for the first time of a targeted medication.</p> <p>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, along with the preferred medications.</p> <p>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.</p>

Optional riders

<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p>Note: These riders are only available as part of a prescription drug package.</p> <p>Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.)</p> <p>Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>
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