



## Community Blue<sup>SM</sup> PPO 3 – Plan 1 Medical Coverage Benefits-at-a-Glance with \$15/50/50% Rx coverage

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 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.

	In-network	Out-of-network *
<b>Member's responsibility (deductibles, copays and dollar maximums)</b>		
<b>Deductibles</b>	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Deductible may be waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Fixed dollar copays</b>	<ul style="list-style-type: none"> <li>\$25 copay for office visits</li> <li>\$150 copay for emergency room visits</li> </ul>	\$150 copay for emergency room visits
<b>Percent copays</b> <b>Note:</b> Copays apply once the deductible has been met.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>40% of approved amount for most other covered services</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
<b>Annual copay dollar maximums</b> – applies to copays for all covered services – including mental health and substance abuse services – but <b>does not</b> apply to fixed dollar copays and private duty nursing percent copays <b>Note:</b> For groups with 50 or fewer employees or groups that are <b>not</b> subject to the MHP law, mental health care and substance abuse treatment copays <b>do not</b> contribute to the copay dollar maximum.	\$1,000 for one member, \$2,000 for two or more members each calendar year	\$3,000 for one member, \$6,000 for two or more members each calendar year <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Lifetime dollar maximum</b>	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"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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) <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible <b>Note:</b> 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% (no deductible or copay) for the first billed colonoscopy <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	

**Physician office services**

Office visits	\$25 co pay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$25 co pay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$25 co pay per office visit	60% after out-of-network deductible, must be medically necessary

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**In-network**

**Out-of-network \***

**Emergency medical care**

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	80% after in-network deductible	80% after in-network deductible

**Diagnostic services**

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

**Maternity services provided by a physician**

Prenatal and postnatal care	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

**Hospital care**

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

**Alternatives to hospital care**

Skilled nursing care – must be in a <b>participating</b> skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	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 <b>participating</b> hospice program <b>only</b> ; 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 and provided by a <b>participating</b> home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by <b>participating</b> home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

**Surgical services**

Surgery – includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% 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 <b>only</b>
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible
	In-network	Out-of-network

**Mental health care and substance abuse treatment**

Inpatient mental health care	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 80% after deductible	Covered – 60% after deductible
	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	Covered – 80% after deductible	Covered – 60% after deductible

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**In-network**

**Out-of-network \***

**Other covered services**

Outpatient Diabetes Management Program (ODMP) <b>Note:</b> Effective July 1, 2011, 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% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$25 co pay per office visit Limited to a <b>combined</b> maximum of 24 visits per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible Limited to a <b>combined</b> maximum of 60 visits per member per calendar year	60% after out-of-network deductible <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

**Optional riders**

<b>Rider CB-ET \$150</b> , emergency treatment copay requirement	Increases copay for outpatient hospital emergency room services to \$150.
<b>Rider CB-OV\$25</b> , office visit copay requirement	Increases copay for select office visits to PPO network providers to \$25.
<b>Rider XVA</b> , excludes voluntary abortions	Excludes benefits for voluntary abortions.
<b>Rider CI</b> , contraceptive injections <b>Rider PCD</b> , prescription contraceptive devices <b>Rider PD-CM</b> , prescription contraceptive medications	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). <b>Note:</b> These riders are only available as part of a prescription drug package. 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.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.

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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<sup>®</sup> and Humira<sup>®</sup>) 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](http://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) once applicable deductible has been met.**

**Member’s responsibility (copays)**

		<b>90-day retail network pharmacy</b>	<b>* Network mail order provider</b>	<b>Network pharmacy (not part of the 90-day retail network)</b>	<b>Non-network pharmacy</b>
<b>Tier 1 –</b> Generic or prescribed over-the-counter drugs	1 to 30-day period	\$15 copay	\$15 copay	\$15 copay	\$15 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$30 copay	No coverage	No coverage
	84 to 90-day period	\$30 copay	\$30 copay	No coverage	No coverage
<b>Tier 2 –</b> Formulary (preferred) brand-name drugs	1 to 30-day period	\$50 copay	\$50 copay	\$50 copay	\$50 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$100 copay	No coverage	No coverage
	84 to 90-day period	\$100 copay	\$100 copay	No coverage	No coverage

**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

\* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

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**Member's responsibility (copays), *continued***

		<b>90-day retail network pharmacy</b>	<b>* Network mail order provider</b>	<b>Network pharmacy (not part of the 90-day retail network)</b>	<b>Non-network pharmacy</b>
<b>Tier 3 – Nonformulary (nonpreferred) brand-name drugs</b>	1 to 30-day period	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100	\$70 or 50% of the approved amount (whichever is greater), but no more than \$100 <b>plus</b> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	84 to 90-day period	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	\$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage

**Covered services**

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 BCBSM	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
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <b>Note:</b> 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

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### Features of your prescription drug plan

<b>BCBSM Custom Formulary</b>	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM 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.</p> <ul style="list-style-type: none"><li>▪ <b>Tier 1 (generic)</b> – 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.</li><li>▪ <b>Tier 2 (preferred brand)</b> – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay.</li><li>▪ <b>Tier 3 (nonpreferred brand)</b> – 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.</li></ul>
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<p><b>Prior authorization/step therapy</b></p>	<p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. <b>Step Therapy</b>, 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 <a href="http://bcbsm.com">bcbsm.com</a>. Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i>.</p>
<p><b>Mandatory maximum allowable cost drugs</b></p>	<p>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 <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonpreferred 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. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
<p><b>Drug interchange and generic copay waiver</b></p>	<p>BCBSM'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 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><b>Quantity limits</b></p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. A list of these drugs is available at <a href="http://bcbsm.com">bcbsm.com</a>.</p>

**Optional riders**

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