



Community BlueSM PPO 1 - Plan 2 w/ \$15/50/50%Rx Benefits-at-a-Glance for Saginaw Valley State University Group #68859

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

In-network

Out-of-network

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

Note: Services from a provider for which there is no 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. 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.

Deductibles	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Copays		
• Fixed dollar copays	\$20 for office visits and \$100 for emergency room visits	\$100 for emergency room visits
• Percent copays	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums		
• Fixed dollar copays	None	None
• Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	Not applicable	\$2,000 for one member, \$4,000 for two or more members each calendar year
Lifetime dollar maximum	None	

Preventive care services – *Payment for preventive services is unlimited

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 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 PPACA.	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

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

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In-network

Out-of-network

Mammography

Mammography screening	Covered – 100% (no deductible or co pay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent co pay	Covered – 80% after deductible Note: Non-network reading and interpretations are payable only when the screening mammogram itself is performed by a network provider
One per calendar year, no age restrictions		

Physician office services

Office visits	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay per office visit	Covered – 80% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$100 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%

Diagnostic services

Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	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	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%



Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy – routine or medically necessary	Covered – 100% for routine colonoscopy (no deductible or copay) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	No lifetime dollar maximum	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100%	Covered – 80% after deductible

Mental health care and substance abuse treatment

Inpatient mental health care	Covered – 80%	Covered – 80% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 80%	Covered – 80% after deductible
	Unlimited days, up to \$15,000 annual maximum	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 80%	Covered – 80%
	Covered – 80%	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 80%	Covered – 80%
	Up to the state-dollar amount that is adjusted annually	

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – \$20 copay per office visit	Covered – 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%

Additional Riders

Rider CB-ET \$100 , emergency treatment copay requirement	Increases dollar copay for outpatient hospital emergency room services to \$100.
Rider CB-OV\$20 , office visit copay requirement	Increases copay for select office visits to PPO network providers to \$20.



Rider CBC-MT , copay requirement for manipulative treatment	Imposes the same fixed dollar copay requirement for chiropractic and osteopathic manipulative treatment by a network provider as is required for all network physician office visits.
Rider CB-MH 20% , mental health / substance abuse treatment copay requirement	Decreases copay to 20% for mental health care services and substance abuse treatment provided by both network and non-network providers.

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) once applicable deductible has been met.

Member’s responsibility (copays)

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	\$15 copay	\$15 copay	\$15 copay	\$15 copay plus 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
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	\$50 copay	\$50 copay	\$50 copay	\$50 copay plus 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.



Member's responsibility (copays), *continued*

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	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 plus 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 Note: 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

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

Features of your prescription drug plan

BCBSM Custom Formulary	<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"> ▪ Tier 1 (generic) – 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. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ Tier 3 (nonpreferred brand) – 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.
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<p>Prior authorization/step therapy</p>	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, 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 bcbsm.com. Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i>.</p>
<p>Mandatory maximum allowable cost drugs</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 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 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. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
<p>Drug interchange and generic copay waiver</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>Quantity limits</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 bcbsm.com.</p>

Additional 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 IUDs, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered). Note: 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 network 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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