



Community BlueSM PPO – Plan 1 w/ \$10/40 Rx Benefits-at-a-Glance for Saginaw Valley State University Group #68859-663

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

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In-network

Out-of-network

Mammography

Mammography screening	Covered – 100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay	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%
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 Up to a maximum of 24 visits per member per calendar year	Covered – 80% after deductible
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.

Note: The mail order pharmacy for **specialty drugs** is Option Care, 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. Option Care 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 Blue 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 Option Care customer service at 866-515-1355.

Network pharmacy

Non-network pharmacy

Member's responsibility (copays)

Generic prescription drugs	\$10 copay for each drug	\$10 copay for each drug plus 25% of BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM	\$10 copay for each drug	\$10 copay for each drug plus 25% of BCBSM approved amount for the drug
Brand name prescription drugs	\$40 copay for each drug	\$40 copay for each drug plus 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<p>Copay for up to a 34 day supply:</p> <ul style="list-style-type: none"> • \$10 copay for each generic drug • \$40 copay for each brand name drug <p>Copay for a 35 to 90 day supply:</p> <ul style="list-style-type: none"> • \$20 copay for each generic drug • \$80 copay for each brand name drug 	No coverage

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 has not indicated "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.

Covered services

"Rx only" drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% 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, an independent company (BCBSM network mail order provider)	Covered – 100% less plan copay	No coverage

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

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

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Features of your 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>

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 "Rx only" oral or injectable contraceptive medications.</p> <p>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, 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.</p>
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