



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

WAYNE COUNTY COMMUNITY COLLEGE DISTRICT
61298660
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Effective Date: 01/01/2017

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/coinsurance. 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.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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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.

Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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

Benefits	In-network	Out-of-network
Deductible	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	<ul style="list-style-type: none"> \$10 copay for office visits and office consultations \$10 copay for online visits \$10 copay for urgent care visits 	
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services
Note: Coinsurance amounts apply once the deductible has been met.		
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$600 for one member, \$1,200 for the family (when two or more members are covered under your contract) each calendar year	\$2,250 for one member, \$4,500 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 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/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
		One per member per calendar year
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
		One per member per calendar year

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$10 copay per office visit	80% after out-of-network deductible
Online visits - by physician must be medically necessary	\$10 copay per online visit	80% after out-of-network deductible
Note: Online visits by a vendor are not covered.		
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	\$10 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$10 copay per urgent care visit	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chemotherapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Limited to a maximum of 120 days per member per calendar year.		

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Benefits	In-network	Out-of-network
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	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)	
Home health care: <ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Infusion therapy: <ul style="list-style-type: none"> must be medically necessary must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) may use drugs that require preauthorization - consult with your doctor 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary sterilization for males	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary abortions	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
	Unlimited days	

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Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) in participating facilities only
<ul style="list-style-type: none"> Physician's office 	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> 100% (no deductible or copay/coinsurance) for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance) Limited to a combined 24-visit maximum per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 60-visit maximum per member per calendar year

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Benefits	In-network	Out-of-network
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)

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BCBSM Preferred RX Program

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/coinsurance. 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.

Specialty Pharmaceutical 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, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network 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 Express Scripts. (Express Scripts 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/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Copay	You pay nothing	You pay 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	You pay nothing	Not covered

Note: An in-network pharmacy is a Preferred Rx pharmacy in Michigan or an Express Scripts pharmacy outside Michigan. Express Scripts is an independent company providing pharmacy benefit services for Blues members. An out-of-network pharmacy is a pharmacy NOT in the Preferred Rx or Express Scripts networks.

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

Benefits	In-network pharmacy	Out-of-network pharmacy
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 Patient Protection and Affordable Care Act	100% of approved amount	75% of approved amount
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Note: Needles and syringes have no copay/ coinsurance.		

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Features of your prescription drug plan	
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance 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/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.