



**Group:** National Employees Health Plan  
**Group No:** 44116-056

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.

## Community Blue<sup>SM</sup> PPO Health Care Coverage Benefits-at-a-Glance

Member's responsibility (deductibles, copays and dollar maximums)		
Benefits	In-network	Out-of-network
<b>Deductibles</b>	\$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> Deductible waived if service is performed in a PPO physician's office except for mental health and substance abuse services.	\$1,000 for one member \$2,000 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>\$50 copay for emergency room visits</li> </ul>	\$50 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 mental health care and substance abuse treatment</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>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>40% of approved amount for mental health care and substance abuse treatment</li> <li>40% of approved amount for most other covered services</li> </ul>
<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	\$1,000 for one member \$2,000 for two or more members each calendar year	\$2,000 for one member \$4,000 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.



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% of approved amount, one per member per calendar year	Not covered
Routine gynecological exam	100% of approved amount, one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% of approved amount, one per member per calendar year	Not covered
Well-baby and child care visits	100% of approved amount <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% of approved amount	Not covered
Fecal occult blood screening	100% of approved amount, one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% of approved amount, one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% of approved amount, one per member per calendar year	Not covered
Routine mammogram and related reading – one routine mammogram per member per calendar year	100% of approved amount <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.
Colonoscopy – routine or medically necessary – one routine colonoscopy per member per calendar year	100% of approved amount for routine colonoscopy <b>Note:</b> Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible

Physician office services		
Benefits	In-network	Out-of-network
Office visits	\$25 copay 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 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$25 copay per office visit	60% after out-of-network deductible, must be medically necessary

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Emergency medical care		
Benefits	In-network	Out-of-network
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	80% after in-network deductible	80% after in-network deductible

Diagnostic services		
Benefits	In-network	Out-of-network
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 or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal and postnatal care	100% of approved amount	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% 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 – unlimited days <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
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		
Benefits	In-network	Out-of-network
Skilled nursing care – limited to 90 days per member per calendar year and must be in a <b>participating</b> skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Hospice care – 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	100% of approved amount	100% of approved amount
Home health care – must be medically necessary and provided by a <b>participating</b> hospital	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

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<b>Surgical services</b>		
<b>Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
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% of approved amount	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

<b>Human organ transplants</b>		
<b>Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
Specified human organ transplants – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	100% of approved amount, in designated facilities <b>only</b>	
Bone marrow transplants – when coordinated through 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

<b>Mental health care and substance abuse treatment</b>		
<b>Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
Inpatient mental health care and inpatient substance abuse treatment – unlimited days	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care	Facility and clinic	80% after in-network deductible
	Physician's office	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	80% after in-network deductible	80% after in-network deductible

<b>Other covered services</b>		
<b>Benefits</b>	<b>In-network</b>	<b>Out-of-network</b>
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	100% of approved amount	60% after out-of-network deductible
Prescription contraceptive devices	100% after in-network deductible	60% after out-of-network deductible
Contraceptive injections	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy – limited to a <b>combined</b> maximum of 24 visits per member per calendar year	\$25 copay per visit	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – limited to a <b>combined</b> maximum of 60 visits per member per calendar year	80% after in-network deductible	60% after out-of-network deductible
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

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## Blue Preferred<sup>®</sup> Rx Prescription Drug Coverage Benefits-at-a-Glance

### Member's responsibility (copays)

**Note:** If you have a prescription filled by any type of network pharmacy, and the pharmacist fills it a brand-name drug when a generic equivalent drug is available on the BCBSM MAC list, 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.

Benefits		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Generic or prescribed over-the-counter drugs	1 to 30-day period	\$15 copay	\$15 copay	\$15 copay	\$15 copay <b>plus</b> 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
Brand-name drugs	1 to 30-day period	\$30 copay	\$30 copay	\$30 copay	\$30 copay <b>plus</b> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$60 copay	No coverage	No coverage
	84 to 90-day period	\$60 copay	\$60 copay	No coverage	No coverage

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

### Covered services

Benefits	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
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
Prescription contraceptive medications	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

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



**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.

**Effective July 1, 2010, 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).**

Features of your prescription drug plan	
<b>Drug interchange and generic copay waiver</b>	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 <a href="http://bcbsm.com">bcbsm.com</a> . 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.
<b>Quantity limits</b>	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 <a href="http://bcbsm.com">bcbsm.com</a> .
<b>Mandatory preauthorization</b>	A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com">bcbsm.com</a> . Log in under "I am a Member" and click on "Prescription Drugs."