



**Blue Cross
Blue Shield
of Michigan**

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

Macomb Community College

Group Number: 71705 Package Code(s): 021, 041

Division Code(s): 4000, 4100

PPO - HDHP PPO, Rx2, Single, Family

Effective Date: 06/01/2023

Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (<https://www.bcbsm.com/importantinfo>). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% Note: Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	\$3,000 per member \$6,000 per family Includes Deductible, Coinsurance and Copays	\$6,000 per member \$12,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services		
Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 80% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 80% after deductible
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 80% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 80% after deductible

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Benefits	In-Network	Out-of-Network
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 80% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care <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	Covered - 100%	Covered - 80% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 80% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Visits	Covered - 100% after deductible	Covered - 80% after deductible
Blue Cross Online Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after deductible	Not Covered
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible	Covered - 100% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Physician Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible

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Benefits	In-Network	Out-of-Network
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Elective Abortions	Covered - 100% after deductible	Covered - 80% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Blue Cross Online Mental Health Care Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after deductible	Not Covered

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Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 100% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 100% after deductible
Private Duty Nursing Care	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Facility Clinic Visit	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

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Macomb Community College
Group Number: 71705 Package Code(s): 021, 041
Division Code(s): 4000, 4100
Prescription Drugs
Effective Date: 08/01/2023
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)	
Benefits	Coverage
Deductible	\$2,000 per member \$4,000 per family
Retail - 30-day supply	\$15 copay after deductible - Generic drugs \$40 copay after deductible - Preferred brand drugs \$80 copay after deductible - Non-Preferred brand drugs 20% coinsurance after deductible - Generic and Preferred Specialty drugs \$200 maximum 20% coinsurance after deductible - Non-Preferred Specialty drugs \$300 maximum Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	\$30 copay after deductible - Generic drugs \$80 copay after deductible - Preferred brand drugs \$160 copay after deductible - Non-Preferred brand drugs
Specialty Drugs Exclusive Specialty Network: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: 20% coinsurance after deductible - Generic and Preferred Specialty drugs \$200 maximum 20% coinsurance after deductible - Non-Preferred Specialty drugs \$300 maximum Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.

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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 PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
Diabetic Supplies	<p>Includes: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit</p> <p>Retail Test Strips and Lancets: \$40 copay after deductible</p> <p>Mail Order Test Strips and Lancets: \$40 copay after deductible</p>

Features of your prescription drug plan	
Prior authorization/step therapy	<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. 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/pharmacy.</p>

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