



Blue Cross
Blue Shield
of Michigan

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

DELTA COLLEGE

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Community Blue PPOSM ASC

Effective Date: On or after January 2016

Benefits-at-a-glance

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.

BCBSM provides administrative claims services only. Your employer 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.

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

Benefits	In-network	Out-of-network
Deductible	<p>\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$250 for one member \$500 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$25 copay for office visits and office consultations \$25 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits \$40 copay for urgent care visits 	<ul style="list-style-type: none"> \$150 copay for emergency room visits
<p>Coinsurance amounts (percent copays)</p> <p>Note: Coinsurance amounts apply once the deductible has been met.</p>	<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 abuse treatment 20% of approved amount for most other covered services
<p>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</p>	<p>\$6,600 for one member \$13,200 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$2,000 for one member \$4,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>
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	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p> <p>Note: Additional well-women visits may be allowed based on medical necessity</p>	Not covered
Gynecological exam	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p> <p>Note: Additional well-women visits may be allowed based on medical necessity.</p>	Not covered
Pap smear screening - laboratory and pathology services - one per member per calendar year	<p>100% (no deductible or copay/coinsurance), one per member per calendar year</p>	Not covered
Voluntary Sterilization for Females	<p>100% (no deductible or copay/coinsurance)</p>	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	\$25 copay for each office visit after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	\$25 copay for each office visit after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	\$25 copay for each office consultation after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$40 copay per urgent care visit after in-network deductible	80% after out-of-network deductible

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Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$150 copay per visit after in-network deductible (copay and deductible waived if admitted or for an accidental injury)	\$150 copay per visit after in-network deductible (copay and deductible waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	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% after in-network deductible	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% after in-network deductible	80% after out-of-network deductible Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	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% after in-network deductible	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year.
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% after in-network deductible	100% after in-network deductible

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Benefits	In-network	Out-of-network
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% after in-network deductible	100% after in-network deductible

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% after in-network deductible	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% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary Abortions	100% after in-network deductible	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% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse 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 abuse treatment	100% after in-network deductible	80% after out-of-network deductible
		Unlimited days
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% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> • Facility and clinic 	100% after in-network deductible	100% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> • Physician's office 	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities only	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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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% after in-network deductible 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	\$25 copay per visit after in-network deductible 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% after in-network deductible Limited to a combined 60-visit maximum per member per calendar year	80% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
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% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BCBSM Preferred RX Program
Effective Date: On or after January 2016
Benefits-at-a-glance**

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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		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$20 copay	You pay \$20 copay	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$40 copay	No coverage	No coverage
	84 to 90-day period	You pay \$40 copay	You pay \$40 copay	No coverage	No coverage

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$60 copay	You pay \$60 copay	You pay \$60 copay	You pay \$60 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$120 copay	No coverage	No coverage
	84 to 90-day period	You pay \$120 copay	You pay \$120 copay	No coverage	No coverage

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

Covered services				
Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	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	100% of approved amount less plan copay/coinsurance	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	100% of approved amount less plan copay/coinsurance	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 (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/ coinsurance	100% of approved amount less plan copay/ coinsurance	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 Note: Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	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
Elective drugs Note: Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.	50% of approved amount	50% of approved amount	50% of approved amount	50% of approved amount

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

Features of your prescription drug plan

Custom Drug List	<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 drug list 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/coinsurance, making them the most cost-effective option for the treatment. • Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • 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/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</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/ 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.</p>

Prescription drug preferred therapy	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.</p> <p>Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications.</p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by an in-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/coinsurance 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/coinsurance.</p> <p>Note: This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.



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Vision Coverage

Effective Date: On or after January 2016

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Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)		
Benefits	Participating provider	Nonparticipating provider
Eye exam	\$5 copay	\$5 copay
Prescription glasses (lenses and/or frames)	A combined \$7.50 copay	No copay (member responsible for difference between approved amount and provider's charge)
Medically necessary contact lenses	\$7.50 copay	No copay (member responsible for difference between approved amount and provider's charge)

Eye exam		
Benefits	Participating provider	Nonparticipating provider
Complete eye exam by a physician or optometrist	\$5 copay	75% of approved amount less \$5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and Frames		
Benefits	Participating provider	Nonparticipating provider
Standard lenses, not to exceed 65 mm in diameter, when prescribed or dispensed by a physician, optometrist or optician	\$7.50 copay (one copay applies to both lenses and frames)	Covered up to approved amount based on lens type (member responsible for any difference)
One pair of lenses, with or without frames, in any period of 12 consecutive months		
Standard frames	Covered up to \$61.07 (member responsible for any cost exceeding approved amount) less \$7.50 copay (one copay applies to both lenses and frames)	Covered up to a maximum payment of \$14 (member responsible for any difference)
One frame in any period of 12 consecutive months		

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

Contact Lenses

Benefits	Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> Medically necessary contact lenses (must meet criteria of medically necessary) 	\$7.50 copay One pair of contact lenses in any period of 12 consecutive months	Covered up to a maximum payment of \$96 (member responsible for any difference)
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered up to a maximum payment of \$35 (member responsible for any difference) One pair of contact lenses in any period of 12 consecutive months	Covered up to a maximum payment of \$35 (member responsible for any difference)



**Blue Cross
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**DELTA COLLEGE
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Hearing Care Coverage
Effective Date: On or after January 2016
Benefits-at-a-glance**

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 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.

Member's responsibility (deductible and copay)		
Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural hearing aid only) - one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.