



Blue Cross
Blue Shield
of Michigan

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

MUSKEGON COMMUNITY COLLEGE

A1GHK5

0070045530012

Community Blue PPOSM ASC

Effective Date: On or after January 2022

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. If your group is self-funded, please see any other plan documents your group uses. 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.

ADM PLANR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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>\$1,000 for one member, \$2,000 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 use disorder services that are equivalent to an office visit and performed in an in-network physician's office.</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 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 with a primary care physician • \$40 copay for office visits and office consultations with a specialist • \$25 copay for chiropractic and osteopathic manipulative therapy • \$150 copay for emergency room visits • \$60 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 • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) | <ul style="list-style-type: none"> • 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services |
| <p>Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</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>\$4,000 for one member, \$8,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p> |
| <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>\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year</p> | <p>\$12,700 for one member, \$25,400 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 | |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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% (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) | 60% after out-of-network deductible |
| 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) | 60% 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 |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.

| Benefits | In-network | Out-of-network |
|--|--|--|
| 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, if applicable. | 60% 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, if applicable. | 60% 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 | <ul style="list-style-type: none"> \$25 copay for each office visit with a primary care physician \$40 copay for each office visit with a specialist | 60% after out-of-network deductible |
| Online visits - by physician or BCBSM selected vendor must be medically necessary | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary | 80% after in-network deductible | 60% after out-of-network deductible |
| Office consultations - must be medically necessary | <ul style="list-style-type: none"> \$25 copay for each office consultation with a primary care physician \$40 copay for each office consultation with a specialist | 60% after out-of-network deductible |
| Urgent care visits - must be medically necessary | \$60 copay per urgent care visit | 60% after out-of-network deductible |

| Emergency medical care | | |
|--|--|--|
| Benefits | In-network | Out-of-network |
| Hospital emergency room | \$150 copay per visit (copay waived if admitted or for an accidental injury) | \$150 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 |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.

| Benefits | In-network | Out-of-network |
|-----------------------------|---------------------------------|-------------------------------------|
| 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 care visits | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Postnatal care visit | 100% (no deductible or copay/coinsurance) | 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 | 80% after in-network deductible | 60% after out-of-network deductible |
| Note: Nonemergency services must be rendered in a participating hospital. | Unlimited days | |
| 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 - must be in a participating skilled nursing facility | 80% after in-network deductible | 80% 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 | 80% after in-network deductible | 80% after in-network deductible |
| 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 | 80% after in-network deductible | 80% after in-network deductible |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.

Surgical services

| Benefits | In-network | Out-of-network |
|--|---|---|
| Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility | 80% after in-network deductible | 60% after out-of-network deductible |
| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Voluntary sterilization for males | 80% after in-network deductible | 60% after out-of-network deductible |
| Note: For voluntary sterilizations for females, see " Preventive care services. " | | |
| Voluntary abortions | 80% after in-network deductible | 60% after out-of-network deductible |
| Removal of Wisdom teeth (impacted and non-impacted) - includes surgery and related anesthesia | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) |

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) | 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 |
| Note: BCBSM covers clinical trials in compliance with PPACA. | | |
| Kidney, cornea and skin transplants | 80% after in-network deductible | 60% after out-of-network deductible |

Behavioral Health Services (Mental Health and Substance Use Disorder)

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

| Benefits | In-network | Out-of-network |
|--|---------------------------------|---|
| Inpatient mental health care and inpatient substance use disorder treatment | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic | 80% after in-network deductible | 80% after in-network deductible in participating facilities only |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.

| Benefits | In-network | Out-of-network |
|--|---------------------------------|---|
| <ul style="list-style-type: none"> Online visits - by physician or BCBSM selected vendor must be medically necessary | \$25 copay per online visit | 60% after out-of-network deductible |
| <ul style="list-style-type: none"> Physician's office | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient substance use disorder treatment - in approved facilities only | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 80% after in-network deductible |
| <p>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.</p> | | |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder | 80% after in-network deductible | 60% after out-of-network deductible |
| | Physical, speech and occupational therapy with an autism diagnosis is unlimited | |
| Other covered services, including mental health services, for autism spectrum disorder | 80% after in-network deductible | 60% after out-of-network deductible |

Other covered services

| Benefits | In-network | Out-of-network |
|--|--|--|
| Outpatient Diabetes Management Program (ODMP) | <ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training | 60% after out-of-network deductible |
| <p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p> | | |
| Allergy testing and therapy | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | \$25 copay per visit | 60% after out-of-network deductible |
| | Limited to a combined 24-visit maximum per member per calendar year | |
| Outpatient physical, speech and occupational therapy - provided for rehabilitation | 80% after in-network deductible | 60% after out-of-network deductible |
| | | <p>Note: Services at nonparticipating outpatient physical therapy facilities are not covered.</p> |
| | Limited to a combined 60-visit maximum per member per calendar year | |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.

| 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. | 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 care | 50% after in-network deductible | 50% after in-network deductible |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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 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. 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.



**Blue Cross
Blue Shield**
of Michigan

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

MUSKEGON COMMUNITY COLLEGE

A1GHK5

0070045530012

BCBSM Preferred RX Program

Effective Date: On or after January 2022

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.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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. AllianceRx Walgreens Prime 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 the OptumRx home delivery pharmacy. (OptumRx 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 AllianceRx Walgreens Prime 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 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The 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 \$10 copay | You pay \$10 copay | You pay \$10 copay | You pay \$10 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay \$20 copay | No coverage | No coverage |

ADM PLANR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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

| 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 | 84 to 90-day period | You pay \$20 copay | You pay \$20 copay | No coverage | No coverage |
| | 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 |
| Tier 3 - Nonpreferred brand-name drugs** | 84 to 90-day period | You pay \$80 copay | You pay \$80 copay | No coverage | No coverage |
| | 1 to 30-day period | You pay \$80 copay | You pay \$80 copay | You pay \$80 copay | You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay \$160 copay | No coverage | No coverage |
| Tier 4 - Generic and preferred brand-name specialty drug | 84 to 90-day period | You pay \$160 copay | You pay \$160 copay | No coverage | No coverage |
| | 1 to 30-day period | You pay 50% of the approved amount, but no more than \$100 | You pay 50% of the approved amount, but no more than \$100 | You pay 50% of the approved amount, but no more than \$100 | You pay 50% of the approved amount, but no more than \$100 plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | No coverage | No coverage | No coverage |
| Tier 5 - Nonpreferred brand-name specialty drugs | 84 to 90-day period | No coverage | No coverage | No coverage | No coverage |
| | 1 to 30-day period | You pay 50% of the approved amount, but no more than \$200 | You pay 50% of the approved amount, but no more than \$200 | You pay 50% of the approved amount, but no more than \$200 | You pay 50% of the approved amount, but no more than \$200 plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | No coverage | No coverage | No coverage |
| | 84 to 90-day period | No coverage | No coverage | 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 |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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

| 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 |
|---|---|---|---|--|
| 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 | 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 | 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 |
| 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 | No coverage | 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 | 100% of approved amount | 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 | 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 | 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 |
| Note: Needles and syringes have no copay/coinsurance. | | | | |
| Select diabetic supplies and devices (test strips, lancets and glucometers) | 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 |
| For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy . | | | | |

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

ADM PLAN1YR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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

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. • Tier 4 (generic and preferred brand-name specialty) - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance. • Tier 5 (nonpreferred brand-name specialty) - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance. |
| 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 preauthorization) 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. 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 bcbsm.com/pharmacy.</p> |
| Mandatory maximum allowable cost drugs | <p>If your prescription is filled by any type of 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 regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary 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. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p> |
| Quantity limits | <p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p> |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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



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

MUSKEGON COMMUNITY COLLEGE

A1GHK5

0070045530012

Dental Coverage

Effective Date: On or after January 2022

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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call **1-888-826-8152**.

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

Blue Par SelectSM arrangement- Most non-PPO(out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, and members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

Note: For members who go to nonparticipating dentists we will pay the charge for covered services, less the members applicable deductible and/or copayment directly to the subscriber. The providers charge will constitute our approved amount.

Member's responsibility (deductible, coinsurance and dollar maximums)

| Benefits | Coverage |
|--|----------|
| Deductible | None |
| Coinsurance (percentage of BCBSM's approved amount for covered services) | 20% |
| • Class I services | |
| • Class II services | 20% |
| • Class III services | 20% |
| • Class IV services | 40% |

ADM PLAN YR JAN; ASCMOD 10167DRG; ASCMOD 7825 DEN; ASCMOD 9213 MED; BLUE DENTAL; BLUE VISION; BV-PL; BVFL; BVPP CHOICE NET; CB ASC; CB-AMB ASC; CB-DPP-ASC; CB-ECM-IN \$2K A; CB-ECM-ON \$4K A; CB-ET \$150 ASC; CB-MTC \$25 ASC; CB-OLV\$0ASC; CB-OPMIN 6350 A; CB-OV \$25 ASC; CBC 20%-IN ASC; CBC 40%-ON ASC; CBD \$1K-IN ASC; CBD \$2K-ON ASC; CBOPMON 12.7K A; CDH-FSA-DC-FSA; DO-PPO; HCP PL2 ASC; HEQ; PDRX ASC; PK067; SP10408015%253K

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

| Benefits | Coverage |
|---|--------------------|
| Dollar maximums | \$2,500 per member |
| <ul style="list-style-type: none"> Annual maximum for Class I, II and III services | |
| <ul style="list-style-type: none"> Lifetime maximum for Class IV services | \$1,500 per member |

Class I services

| Benefits | Coverage |
|---|--|
| Oral exams | 80% of approved amount Note: Twice per calendar year |
| A set (up to 4 films) of bitewing x-rays | 80% of approved amount Note: Twice per calendar year |
| Panoramic or full-mouth x-rays | 80% of approved amount Note: Once every 60 months |
| Prophylaxis (cleaning) | 80% of approved amount Note: Twice per calendar year |
| Sealants - for members age 19 and younger | 80% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars |
| Emergency palliative treatment | 80% of approved amount |
| Fluoride treatments | 80% of approved amount Note: Two per calendar year |
| Space maintainers - missing posterior (back) primary teeth - for members 18 and younger | 80% of approved amount Note: Once per quadrant per lifetime |

Class II services

| Benefits | Coverage |
|--|---|
| Fillings - permanent (adult) teeth | 80% of approved amount Note: Replacement fillings covered after 24 months or more after initial filling |
| Fillings - primary (child) teeth | 80% of approved amount Note: Replacement fillings covered after 12 months or more after initial filling |
| Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older | 80% of approved amount Note: Once every 60 months per tooth |
| Recementation of crowns, veneers, inlays, onlays and bridges | 80% of approved amount Note: Three times per tooth per calendar year after six months from original restoration |
| Oral surgery | Not covered |
| Note: Removal of impacted and non-impacted wisdom teeth and related anesthesia is allowed under the medical coverage. | |
| Root canal treatment | 80% of approved amount Note: Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime. |
| Scaling and root planing | 80% of approved amount Note: Once every 24 months per quadrant |
| Limited occlusal adjustments | 80% of approved amount Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months |
| Occlusal biteguards | 80% of approved amount Note: Once every 12 months |

ADM PLAN9R JAN;ASCOD 10167DRG;ASCOD 7825 DEN;ASCOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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

| Benefits | Coverage |
|--|---|
| General anesthesia or IV sedation | 80% of approved amount Note: When medically necessary and performed with oral surgery |
| Repairs and adjustments of a partial or complete denture | 80% of approved amount Note: Six months or more after denture is delivered |
| Relining or rebasing of a partial or complete denture | 80% of approved amount Note: Once per arch in any 36 consecutive months |
| Tissue conditioning | 80% of approved amount Note: Once per arch in any 36 consecutive months |

Class III services

| Benefits | Coverage |
|--|--|
| Removable dentures (complete and partial) | 80% of approved amount Note: Once every 60 months |
| Bridges (fixed partial dentures) - for members age 16 and older | 80% of approved amount Note: Once every 60 months |
| Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement | 80% of approved amount Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31 |

Class IV services - Orthodontic services for dependents under age 19

| Benefits | Coverage |
|--|------------------------|
| Minor treatment for tooth guidance appliances | 60% of approved amount |
| Minor treatment to control harmful habits | 60% of approved amount |
| Interceptive and comprehensive orthodontic treatment | 60% of approved amount |
| Post-treatment stabilization | 60% of approved amount |
| Cephalometric film (skull) and diagnostic photos | 60% of approved amount |

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins.

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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



**Blue Cross
Blue Shield
of Michigan**

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

**MUSKEGON COMMUNITY COLLEGE
A1GHK5
0070045530012
Vision Coverage
Effective Date: On or after January 2022
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. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

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

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance **plus** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

| Member's responsibility (copays) | | |
|---|----------------------------|---|
| Benefits | VSP network doctor | Non-VSP provider |
| Eye exam | \$5 copay | \$5 copay applies to charge |
| Prescription glasses (lenses and/or frames) | Combined \$10 copay | Member responsible for difference between approved amount and provider's charge, after \$10 copay |
| Medically necessary contact lenses | \$10 copay | Member responsible for difference between approved amount and provider's charge, after \$10 copay |
| Note: No copay is required for prescribed contact lenses that are not medically necessary. | | |

| Eye exam | | |
|---|---------------------------|---|
| Benefits | VSP network doctor | Non-VSP provider |
| Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient. | \$5 copay | Reimbursement up to \$45 less \$5 copay (member responsible for any difference) |
| One eye exam in any period of 12 consecutive months | | |

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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

Lenses and frames

| Benefits | VSP network doctor | Non-VSP provider |
|---|--|---|
| <p>Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.</p> <ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor | <p>\$10 copay (one copay applies to both lenses and frames)</p> <p>One pair of lenses, with or without frames, in any period of 12 consecutive months</p> | <p>Reimbursement up to approved amount based on lens type less \$10 copay (member responsible for any difference)</p> |
| <p>Standard frames</p> <p>Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</p> | <p>\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$10 copay (one copay applies to both frames and lenses)</p> <p>One frame in any period of 12 consecutive months</p> | <p>Reimbursement up to \$70 less \$10 copay (member responsible for any difference)</p> |

Contact Lenses

| Benefits | VSP network doctor | Non-VSP provider |
|--|--|--|
| <p>Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)</p> | <p>\$10 copay</p> <p>Contact lenses up to the allowance in any period of 12 consecutive months</p> | <p>Reimbursement up to \$210 less \$10 copay (member responsible for any difference)</p> |
| <p>Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)</p> | <p>\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> <p>Contact lenses up to the allowance in any period of 12 consecutive months</p> | <p>\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</p> |

ADM PLAN YR JAN; ASCMOD 10167DRG; ASCMOD 7825 DEN; ASCMOD 9213 MED; BLUE DENTAL; BLUE VISION; BV-PL; BVFL; BVPP CHOICE NET; CB ASC; CB-AMB ASC; CB-DPP-ASC; CB-ECM-IN \$2K A; CB-ECM-ON \$4K A; CB-ET \$150 ASC; CB-MTC \$25 ASC; CB-OLV\$0ASC; CB-OPMIN 6350 A; CB-OV \$25 ASC; CBC 20%-IN ASC; CBC 40%-ON ASC; CBD \$1K-IN ASC; CBD \$2K-ON ASC; CBOPMON 12.7K A; CDH-FSA-DC-FSA; DO-PPO; HCP PL2 ASC; HEQ; PDRX ASC; PK067; SP10408015%253K

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



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

MUSKEGON COMMUNITY COLLEGE

A1GHK5

0070045530012

Hearing Care Coverage

Effective Date: On or after January 2022

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. If your group is self-funded, please see any other plan documents your group uses. 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)

Note: Limited to a benefit maximum of \$3,000 for monaural hearing aids, \$6,000 for binaural hearing aids every 36 months per member for participating providers

| Benefits | Participating provider | Nonparticipating provider |
|------------|------------------------|---------------------------|
| Deductible | None | None |
| Copay | None | None |

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 or binaural hearing aid) - 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.

ADM PLANYR JAN;ASCMOD 10167DRG;ASCMOD 7825 DEN;ASCMOD 9213 MED;BLUE DENTAL;BLUE VISION;BV-PL;BVFL;BVPP CHOICE NET;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN \$2K A;CB-ECM-ON \$4K A;CB-ET \$150 ASC;CB-MTC \$25 ASC;CB-OLV\$0ASC;CB-OPMIN 6350 A;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOPMON 12.7K A;CDH-FSA-DC-FSA;DO-PPO;HCP PL2 ASC;HEQ;PDRX ASC;PK067;SP10408015%253K

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