

BC/BS COMMUNITY BLUE PPO – CUSTOMIZED PLAN 3

CHANGES TO THIS COVERAGE

Please be advised that EFFECTIVE **APRIL 1, 2011** changes to your Community Blue PPO medical coverage will take effect. An easy-to-read summary that provides a general overview of your benefits is attached.

Your Community Blue PPO – Customized Plan 1 is changing to a Community Blue PPO – Customized Plan 3. The following information is intended to help you better understand your new coverage.

- No monthly premium cost reimbursement

- A cap on preventative care services will no longer exist. Unlimited preventative care will be available for all active and retired employees. In order for a physician's visit or other service to be covered as preventative care, it **must** be coded by a physician as preventative.
 - ❖ **A full list of preventative services this health plan covers is attached for your review**

- Office visit co-pays will increase from \$10 to \$30

- An Emergency Room visit will cost a fee of \$250 if a patient is not admitted to the hospital or coded as an accidental injury – Urgent Care services will be assessed a fee of \$30 as long as they are coded as Urgent Care

- Deductible changes (In-Network)
 - ❖ \$250 for one member
 - ❖ \$500 for the family (when two or more members are covered under your contract)
 - ❖ Fixed dollar co-pays do not apply towards your deductible

- Co-pay dollar maximums (In-network)
 - ❖ \$1,000 for one member
 - ❖ \$2,000 for two or more members each calendar year

Additional changes to your healthcare are described in the attached summary provided by BC/BS. Please be sure to review the attachment, as the changes described above only represent a general overview of the changes that will be made to your healthcare plan.

To better help employees understand the changes to their Community Blue PPO medical coverage, informational sessions coinciding with sessions on changes to prescription drug coverage will be held.

The dates and times for ALL **ACTIVE EMPLOYEES** to meet with BC/BS are Thursday, February 10th and Thursday, February 17th at 11am, 3pm and 5:30pm. The meetings will be held in the Public Safety 2nd floor conference room.

The dates and times for ALL **RETIRED EMPLOYEES** to meet with BC/BS are Thursday, March 3rd and Thursday, March 10th at 11am. The meetings for **RETIRED** employees will be held at the Berkley Public Library.

Community BlueSM PPO – Customized Plan 3 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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed dollar copays	• \$30 copay for office visits • \$250 copay for emergency room visits	\$250 copay for emergency room visits
• Percent copays Note: Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums		
• Percent copay maximums – includes general medical only – excludes fixed dollar copays and private duty nursing percent copays	\$1,000 for one member, \$2,000 for two or more members each calendar year	\$3,000 for one member, \$6,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted for individual services	

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

In-network

Out-of-network *

Preventive care services – **Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%** , one per calendar year	Not covered
Gynecological exam	Covered – 100%** , one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%** , one per calendar year	Not covered
Well-baby and child care	Covered – 100%** <ul style="list-style-type: none"> • 6 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
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered – 100%**	Not covered
Fecal occult blood screening	Covered – 100%** , one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%** , one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%** , one per calendar year	Not covered

Mammography

Mammography screening	Covered – 100%, Removes deductible and copay requirements from screening mammography services provided by PPO network providers.	Covered – 60% after deductible
Rider CB-RM 100, routine mammograms	One per calendar year, no age restrictions	

Physician office services

Office visits	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$250 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Diagnostic services

Laboratory and pathology services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 80% after deductible	Covered – 60% after deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

In-network

Out-of-network *

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes covered services provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	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	
Home health care – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 80% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

In-network

Out-of-network *

Mental health care and substance abuse treatment

Note: If your employer has 51 or more employees (including seasonal and part-time) and is subject to the MHP law, covered mental health care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a copay dollar maximums.

Inpatient mental health care	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 80% after deductible	Covered – 80% after deductible
	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 80% after deductible	Covered – 80% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – \$30 copay per office visit	Covered – 60% after deductible
	Up to a combined maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Optional riders

Rider CBC-MT , copay requirement for manipulative treatment	Imposes the same fixed dollar copay requirement for chiropractic and osteopathic manipulative treatment by a network provider as is required for all network physician office visits.
Rider CB-PCM-500 , preventive care maximum \$500	Increases combined annual benefit maximum for preventive care benefits to \$500.
Rider CB-ET \$250 , emergency treatment copay requirement	Increases dollar copay for outpatient hospital emergency room services to \$250.
Rider CB-OV\$30 , office visit copay requirement	Increases copay for select office visits to PPO network providers to \$30.
Rider CB-RM 100 , routine mammograms	Removes deductible and copay requirements from screening mammography services provided by PPO network providers.
Rider CI , contraceptive injections Rider PCD , prescription contraceptive devices Rider PD-CM , prescription contraceptive medications	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications.</p> <p>Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by network providers.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

BC/BS PRESCRIPTION DRUG COVERAGE

CHANGES TO THIS COVERAGE

Please be advised that EFFECTIVE **APRIL 1, 2011** changes to this prescription drug coverage will take effect. The changes affect ALL City of Berkley active and retired employees. A more detailed and easy-to-read summary of the Blue Preferred Prescription Drug Coverage is attached for your review. The following information is intended to help you better understand your Blue Preferred Prescription Drug Coverage.

BLUE PREFERRED PRESCRIPTION DRUG COVERAGE COSTS:

- No monthly premium cost reimbursement
- Current prescription costs of \$10/\$20 will no longer be in effect on **4/1/2011**
- A three-tier co-pay plan for prescription drug coverage will go into effect on **4/1/2011**. The new plan will be a Custom Formulary plan.
 - ❖ Tier 1 – Generic (Formulary Preferred) - \$5 per/script co-pay
 - ❖ Tier 2 – Formulary Brand (Formulary Options) - \$40 per/script co-pay
 - ❖ Tier 3 – Nonformulary - \$80 per/script co-pay
 - ❖ For information on specific prescriptions and categorized tiers please visit www.bcbs,.com/pdf/custom_formulary_quick_guide.pdf

MAIL ORDER PRESCRIPTION DRUG PROGRAM:

Changes to your Medco Mail Order prescription drug coverage will also be effective on **4/1/2011**.

- 90-day supply of ALL prescription drugs will increase to two co-pays per prescription received
- 90-day supply of ALL prescription drugs can also be obtained at all network pharmacies for the same cost as mail order (2 co-pays)
 - ❖ Tier 1 Generic Drugs - \$10
 - ❖ Tier 2 Formulary Brand - \$80
 - ❖ Tier 3 Nonformulary - \$160

For those employees who would like to speak directly with Blue Cross/Blue Shield representatives and ask specific questions, multiple informational sessions will be held prior to April 1, 2011. The dates and times for ALL **ACTIVE EMPLOYEES** to meet with BC/BS are Thursday, February 10th and Thursday, February 17th at 11am, 3pm and 5:30pm. The meetings will be held in the Public Safety 2nd floor conference room located at 2395 Twelve Mile Road, Berkley, MI 48072.

The dates and times for ALL **RETIRED EMPLOYEES** to meet with BC/BS are Thursday, March 3rd and Thursday, March 10th at 11am. The meetings for **RETIRED** employees will be held at the Berkley Public Library located at 3155 Coolidge Hwy. Berkley, MI 48072.

Blue Preferred[®] Rx Prescription Drug Coverage with \$5 Generic / \$40 Formulary Brand / \$80 Nonformulary Brand Triple-Tier Copay Proposed Benefits-at-a-Glance for City of Berkley #63003

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Note: 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. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 866-515-1355.

Network pharmacy

Non-network pharmacy

Member's responsibility (copays)

Note: If you request a brand name drug when a MAC drug is available, you do not need to pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug. You pay only your copay.

	Network pharmacy	Non-network pharmacy
Tier 1 – Generic prescription drugs	\$5 for each prescription	\$5 for each prescription <i>plus</i> 25% of the BCBSM approved amount for the drug
Tier 2 – Formulary brand-name prescription drugs	\$40 for each prescription	\$40 for each prescription <i>plus</i> 25% of the BCBSM approved amount for the drug
Tier 3 – Nonformulary brand-name prescription drugs	\$80 for each prescription	\$80 for each prescription <i>plus</i> 25% of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 34 day supply: <ul style="list-style-type: none"> • \$5 for each Tier 1 (generic) drug • \$40 for each Tier 2 (formulary brand) drug • \$80 for each Tier 3 (nonformulary brand) drug Copay for a 35 to 90 day supply: <ul style="list-style-type: none"> • \$10 for each Tier 1 (generic) drug • \$80 for each Tier 2 (formulary brand) drug • \$160 for each Tier 3 (nonformulary brand) drug 	No coverage

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Network pharmacy

Non-network pharmacy

Covered services

"Rx only" drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered – 100% less plan copay	No coverage

BCBSM Custom Formulary – 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 formulary is to provide members with the greatest therapeutic value at the lowest possible cost.

- **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, making them the most cost-effective option for the treatment.
- **Tier 2 (Formulary Brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay.
- **Tier 3 (Nonformulary Brand)** – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.

Included riders

Rider CI, Contraceptive injections Rider PCD, Prescription contraceptive devices Rider PD-CM, Prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications. Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
Rider PD-EDC 50%, elective drug 50% copay	Changes copay to 50% for elective drugs. Note: Elective drugs are health habit and reproductive drugs such as those that treat sexual impotency or infertility, help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses; prescribed for medical conditions that have no demonstrable physical harm if not treated.
Rider PD-PT, preferred therapy	Adds a preferred therapy program. Note: The Preferred Therapy Program is a process of deciding if a less costly drug is available for initial prescriptions. With preferred therapy, claims for prescription drugs that do not meet the preferred therapy criteria require demonstrated use of one of the generic products on the Preferred List. Note: This rider is not compatible with Rider RXP.
Rider RX-90-2x, prescription drug 90-day supply 2x	Expands retail coverage of prescription drugs to include a 84 to 90-day supply of medication, subject to one copay that is double the amount that would apply for a 34 day supply (prescriptions with days supply between 35 to 83-days are not covered via retail). Requires all retail 90-day supplies of medication be obtained from a "90-Day Retail Network" provider.

HealthReform

From the Blues Office of National Health Reform



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

You pay **nothing** for preventive health services

Your health plan covers the preventive services listed here in full. That means you can get checkups, vaccines, screenings and more without paying out-of-pocket at your doctor's office. That's right—you don't need to contribute a copay and you don't have to meet your deductible first when you get these services from a provider in our network.

Why? Because visiting your provider regularly for checkups can help keep you healthy and prevent serious and costly medical conditions.

The listed services are covered at 100 percent when you get them from a provider in our network, and when the main purpose of your visit is to get preventive care. These services are not considered preventive when they are part of a visit about an existing illness or injury, or if you get services that are not listed during the same visit.

Group and individual benefit plans may cover additional preventive and immunization services. To obtain your specific benefit information, contact your benefit representative or call customer service using the number found on the back of your Blues ID card.

Covered Exams

- Annual OB/GYN Exam
- Health Maintenance Exam (HME) The following categories will be covered as part of your HME exam when appropriate:
 - Discussions with your doctor about taking aspirin for the prevention of cardiovascular disease (aspirin not payable)
 - Discussions with your doctor about the prevention of iron deficiency anemia for at-risk 6 to 12 month old babies
 - Discussions with your doctor about breast and ovarian cancer susceptibility, genetic risk assessment and BRCA mutation testing
 - Discussions with your doctor about chemoprevention when at high risk for breast cancer
 - Discussions with your doctor about taking a daily supplement containing 0.4 to 0.8 mg of folic acid for women planning or capable of pregnancy (folic acid not payable as a medical benefit)
 - Discussions with your doctor about dental tooth decay or cavity prevention in preschool children (oral fluoride not payable as a preventive benefit)
 - Depression screening
 - High blood pressure screening
 - Screening major depressive disorders in adolescents
 - Obesity screening for adults and children
 - Sexually transmitted infection counseling if sexually active
 - Autism screening
 - Developmental surveillance
 - Psychosocial and behavioral assessment
 - Alcohol and drug use assessment
 - Oral health (basic check of child's mouth/teeth by primary care provider/pediatrician)
 - Anticipatory guidance

The information in this document is based on BCBSM and BCN's current understanding of the Patient Protection and Affordable Care Act (PPACA) and is not intended to impart legal advice. Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to revise and update the information in this document as it becomes available. This document is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and should not be relied upon as legal or compliance advice. Analysis of the law is ongoing and additional guidance is expected from the Department of Health and Human Services. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members are encouraged to consult with their benefit administrators for specific details.

Select groups are not required to comply with the PPACA preventive services provision, such as groups that grandfather preventive benefits and groups that have opted out of PPACA for their retiree plan.

Covered Counseling

- Tobacco use and tobacco-caused disease counseling for pregnant women and adults
- Alcohol behavioral counseling interventions
- Diet behavioral counseling in primary care for adults with cholesterol-related hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
- Recommended interventions during pregnancy and after birth to promote breastfeeding

Your prescription carrier will cover the following medication:

- Topical gonorrhea prophylactic medication (newborns only)

Covered Immunizations

- Influenza (flu)
- Influenza type B
- Pneumococcal (pneumonia)
- Tetanus, diphtheria, pertussis
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Measles, mumps, rubella, and varicella (MMR or MMRV)
- Meningococcal (meningitis)
- Zoster (shingles)
- Rotavirus
- Inactivated polio
- Varicella (chicken-pox)

Covered Screenings

- Abdominal aortic aneurysm (one-time screening for smokers)
- Asymptomatic Bacteriuria — Bacterial urinary infection with no symptoms in pregnant women
- Mammography for breast cancer
- Colorectal cancer
- Congenital hypothyroidism
- Lipid disorders, such as cholesterol or cardiovascular screening
- Osteoporosis for postmenopausal women
- Phenylketonuria (PKU) (newborn test)
- Rh (D) incompatibility (pregnancy related blood test)
- Sickle cell disease
- Type 2 diabetes
- Cervical cancer or dysplasia
- Vision
- Hearing
- Newborn metabolic/hemoglobin
- Hematocrit or hemoglobin (blood test)
- Lead
- Tuberculin test (skin test)
- Sexually Transmitted Infections
 - Chlamydia
 - Gonorrhea
 - Syphilis
 - Aids/HIV
 - Hepatitis B
 - Hepatitis C
 - Herpes
 - Human Papillomavirus (HPV)

Blue Cross Blue Shield of Michigan and Blue Care Network follow the recommendations of national medical societies on service frequencies, age requirements and gender guidance when such requirements are not specifically outlined in the law. All health plans will be updated if the federal regulator issues further guidance that requires the plans to be revised.

The information in this document is based on BCBSM and BCN's current understanding of the Patient Protection and Affordable Care Act (PPACA) and is not intended to impart legal advice. Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to revise and update the information in this document as it becomes available. This document is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and should not be relied upon as legal or compliance advice. Analysis of the law is ongoing and additional guidance is expected from the Department of Health and Human Services. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members are encouraged to consult with their benefit administrators for specific details.

Select groups are not required to comply with the PPACA preventive services provision, such as groups that grandfather preventive benefits and groups that have opted out of PPACA for their retiree plan.