Community Blue Plus℠ – Plan 16
Medical/Surgical Benefits-at-a-Glance

This is intended as an easy-to-read summary. **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.

Deductible, copays and dollar maximums

Note: Services from a provider for which there is no 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. 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
Deductible	$250 for one member, $500 for the family (when two or more members are covered under your contract)each calendar year **Note**: **Deductible 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	$10 for office visits and $100 for emergency room visits	$100 for emergency room visits
• Percent copays	10% for general services, **copay waived if service is performed in a PPO physician's office**, and 50% for mental health care, substance abuse treatment and private duty nursing	40% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums • Fixed dollar copays	None	None
• Percent copays – **excludes** mental health care, substance abuse treatment and private duty nursing copays	$500 for one member, $1,000 for two or more members each calendar year	$4,000 for one member, $8,000 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 per covered specified human organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted for individual services	

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%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	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

Community Blue Plus[SM] – Plan 16
Medical/Surgical Benefits-at-a-Glance

	In-network	Out-of-network
Mammography		
Mammography screening	Covered – 90% after deductible	Covered – 60% after deductible
	One per calendar year, no age restrictions	
Physician office services		
Office visits	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 90% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – $10 copay per office visit	Covered – 60% after deductible, must be medically necessary
Emergency medical care		
Hospital emergency room	Covered – $100 copay per visit, waived if admitted or for an accidental injury	Covered – $100 copay per visit, waived if admitted or for an accidental injury
Ambulance services – medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Diagnostic services		
Laboratory and pathology services	Covered – 90% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 90% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 90% after deductible	Covered – 60% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 90% after deductible	Covered – 60% after deductible
	Includes delivery 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 – 90% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient consultations	Covered – 90% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 60% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 90% after deductible	Covered – 90% after deductible
	Up to 120 days per member per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Home infusion therapy – must be medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 90% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered – 90% after deductible	Covered – 60% after deductible
Voluntary sterilization	Covered – 90% after deductible	Covered – 60% after deductible

Community Blue Plus℠ – Plan 16
Medical/Surgical Benefits-at-a-Glance

	In-network	Out-of-network
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (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 (800-242-3504)	Covered – 90% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 90% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 90% after deductible	Covered – 60% after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient mental health care		
• Facility and clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	
Other covered services		
Outpatient Diabetes Management Program (ODMP)	Covered – 90% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – $10 copay per office visit	Covered – 60% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible	Covered – 60% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 90% after deductible	Covered – 90% after deductible
Prosthetic and orthotic appliances	Covered – 90% after deductible	Covered – 90% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription drugs	Not covered	Not covered

Community Blue Plus[SM] – Plan 16
Medical/Surgical Benefits-at-a-Glance

Optional riders

Rider CB-CSR, cost sharing requirements	Changes the member's cost sharing requirements for out-of-state services. **Note**: This rider is available only to groups in the Upper Peninsula.
Rider CB-ET $150, emergency treatment copay requirement	Increases dollar copay for outpatient hospital emergency room services to $150.
Rider CB-OCSM-12, osteopathic and chiropractic spinal manipulation	Decreases chiropractic visits to 12 visits.
Rider CB-OV$20, office visit copay requirement	Increases copay for select office visits to PPO network providers to $20.
Rider CB-OV$30, office visit copay requirement	Increases copay for select office visits to PPO network providers to $30.
Rider CB-OV$40, office visit copay requirement	Increases copay for select office visits to PPO network providers to $40.
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	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 network providers.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
Rider XVA, excludes voluntary abortions	Excludes benefits for voluntary abortions.

Community Blue Plus℠ – Plan 16
Dental Benefits-at-a-Glance

Network access information

- **DenteMax PPO network** – DenteMax PPO dentists agree to accept our approved amount as payment in full and participate on all claims. DenteMax is an independent company that leases its network to BCBSM to provide access to Blues members. You'll also receive discounts on noncovered services when you use PPO dentists. You can choose from more than 80,000 locations nationwide where dental services are available through our partnership with the **DenteMax** PPO network. To find a **DenteMax** dentist, please call 800-752-1547 or go to the DenteMax Web site at **dentemax.com.**
- **Blue Par Select℠** – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balanced billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com**. Select the **Dental Professionals** subsection of "**Where You Can Go for Care"** page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Copays and dollar maximums

Copays	None
Dollar maximums	
• Annual maximum (for Class I services)	None
• Annual maximum (for Class III and III services)	Not applicable
• Lifetime maximum (for Class IV services)	Not applicable

Class I services

Routine clinical oral exam and evaluation	Covered – 100%, one in a calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, once in a calendar year
Full-mouth and panoramic x-rays	Not covered
Routine dental prophylaxis (teeth cleaning)	Covered – 100%, once in a calendar year
Pit and fissure sealants – for members age 19 or under	Not covered
Palliative (emergency) treatment	Not covered
Fluoride treatment	Not covered
Space maintainers – missing posterior (back) primary teeth	Not covered

Class II services

Fillings – permanent teeth	Not covered
Fillings – primary teeth	Not covered
Onlays, crowns and veneer fillings – permanent teeth	Not covered
Recementing of crowns, veneers, inlays, onlays and bridges	Not covered
Oral surgery including extractions	Not covered
Root canal treatment – permanent tooth	Not covered
Scaling and root planing	Not covered
Limited occlusal adjustments	Not covered
Occlusal biteguards	Not covered
General anesthesia or IV sedation	Not covered
Adjustment of dentures	Not covered
Relining or rebasing of partials or complete dentures	Not covered
Tissue conditioning	Not covered
Repair and adjustments of partial or complete dentures	Not covered

Community Blue Plus[SM] – Plan 16
Dental Benefits-at-a-Glance

Class III services

Removable dentures (complete and partial)	Not covered
Bridges (fixed partial dentures)	Not covered
Endosteal implants	Not covered

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Community Blue Plus[SM] – Plan 16
Vision Benefits-at-a-Glance

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 **800-877-7195** or log onto the VSP Web site at **vsp.com.**

Benefit	Coverage from a VSP network doctor
Eye care wellness – Regular exams are essential for protecting your visual wellness	
Exam One eye exam in an period of 12 **consecutive** months, by an ophthalmologist or optometrist	Covered – $5 copay
Prescription eyewear discounts	
Lenses Your plan provides a 20 percent discount off the VSP doctor's fees for prescription lenses (when a complete pair of glasses is purchased). To receive the discount, lenses must be purchased within 12 months of a covered eye exam, and only through the VSP doctor who performed the exam.	20 percent discount
Frame Your plan provides a 20 percent discount off the VSP doctor's fees for prescription lenses (when a complete pair of glasses is purchased).	20 percent discount
Contact lens evaluation and fitting Your plan provides a 15 percent discount off the cost of your contact lens exam (discount does not apply to eyewear). Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.	15 percent discount
Value added discounts	
Laser VisionCare[SM] – VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's Web site at **vsp.com** to learn more about this exciting program. **Prescription glasses** – Your plan provides unlimited use of the 20 percent discount on glasses as long as an eye exam has been performed in the last 12 months. **Contact lenses** – VSP also offers valuable savings on annual supplies of certain brands of contacts. Visit **vsp.com** or ask your doctor for details.	

Locating your VSP network doctor

When you obtain services from a VSP network doctor, you get the most value from your VSP benefit. VSP offers two convenient ways to locate a VSP doctor near your home or office, or to verify your doctor is a VSP network doctor:

- Visit VSP's Web site at **vsp.com**
- Call VSP Member Services at 800-877-7195

vsp Vision care for life

Community Blue Plus[SM] – Plan 16
Vision Benefits-at-a-Glance

Using your VSP benefit

No cards, no claim forms, no hassles. To access your benefits, simply:

- Make an appointment with a VSP network doctor
- Tell the doctor you are a VSP member when making the appointment
- Provide the doctor with the covered member's identification number

Your doctor and VSP will handle the rest by verifying your benefits and eligibility for services – it's that straightforward.

Non-VSP providers

Although more than 90 percent of VSP members receive care from VSP doctors, you have the option of seeing a non-VSP provider. If you see a non-VSP provider, be aware your out-of-network benefits do not guarantee full payment. For out-of-network reimbursement, pay the entire bill when you receive services and then send your itemized receipt to VSP within six months from your date of service. Included with your receipt should be:

- The name, address and phone number of the non-VSP provider
- The name of the group
- The covered member's name, phone number, address and member identification number
- The patient's name, date of birth, phone number and address
- The patient's relationship to the covered member (such as spouse, child, etc.)

Please keep a copy of the information for your records and send the originals to the following address:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105