Community Blue[SM] PPO Benefits-at-a-Glance Plan 15

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate 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 the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

	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 Visits	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 Immunizations 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
Mammography		
Mammography Screening	Covered – 80% after deductible	Covered – 60% after deductible
	One per calendar year, no age restrictions	
Physician Office Services		
Office Visits	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office Consultations	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Urgent Care Visits	Covered – $30 copay	Covered – 60% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury
Ambulance Services – 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
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 – 80% 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 – 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

	In-Network	Out-of-Network
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home Health Care – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home Infusion Therapy – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Surgical Services		
Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations – with a doctor of medicine, osteopathy, podiatry or an oral surgeon	Covered – 100%	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 (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 – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, Cornea and Skin	Covered – 80% 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 **only**	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	
Other 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 Spinal Manipulation	Covered – 100%	Covered – 60% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic	Covered – 80% after deductible	Covered – 80% after deductible
• Physician's Office – **excludes speech and occupational therapy**	Covered – 100%	Covered – 60% after deductible
	A **combined** 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office	
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
Prescription Drugs	Not covered	Not covered

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.

Deductible	$2,500 per member, $5,000 per family per calendar year **Note: Deductible waived if service is performed in a PPO physician's office.**	$5,000 per member, $10,000 per family per calendar year **Note**: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed Dollar Copays	$30 for office visits and $50 for emergency room visits	$50 for emergency room visits
• Percent Copays	20% for general services, **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	$2,500 per member, $5,000 per family per calendar year	$5,000 per member, $10,000 per family per 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 above for individual services	

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 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 CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and federal legend 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 and are subject to the same deductible and copay, if any, you pay for medical-surgical services. Rider PD-CM is part of your prescription drug coverage and is subject to the same copay you pay for prescription drugs.
Rider XVA, Excludes Voluntary Abortions	Excludes benefits for voluntary abortions.