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CMM-PPO High Option (a Member Value HSASM) Benefits-at-a-Glance

Effective for plan year beginning January 1, 2011

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). 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 update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice.

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 deductibles, coinsurances and copays.

In-Network

Out-of-Network*

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

| | | |
|--|---|---|
| Annual deductible | <ul style="list-style-type: none"> \$2,500 for a one-person contract each calendar year \$5,000 for a family contract each calendar year Covered services for any member under the family contract are only paid after the full family deductible is met. | |
| Fixed dollar copays | None | None |
| Percent coinsurances Note: Coinsurances apply once the deductible has been met. | 50% of approved amount for private duty nursing 20% of approved amount for most covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse coinsurances. | 50% of approved amount for private duty nursing 40% of approved amount for most covered services See "mental health care and substance abuse treatment" section for mental health and substance abuse coinsurances. |
| Annual coinsurance dollar maximums – applies to coinsurances for all covered services, except mental health, substance abuse services, and private duty nursing percent coinsurances. | \$1,000 each calendar year for all covered family members | \$1,000 each calendar year for all covered family members |
| Lifetime dollar maximum | None | |

Preventive care services

| | | |
|---|--|-------------|
| Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Gynecological exam | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Pap smear screening – laboratory and pathology services | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Well-baby and child care visits | 100% (no deductible or copay) <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 |
| 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) | Not covered |
| Fecal occult blood screening | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Flexible sigmoidoscopy exam | 100% (no deductible or copay), one per member per calendar year | Not covered |

In-Network

Out-of-Network*

Preventive care services (continued)

| | | |
|--|---|---|
| Prostate specific antigen (PSA) screening | 100% (no deductible or copay), one per member per calendar year | Not covered |
| Routine mammogram and related reading | 100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay. | 60% after deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider. |
| One per member per calendar year | | |
| Colonoscopy – routine or medically necessary | 100% for routine colonoscopy (no deductible or copay) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay. | 60% after deductible |
| One routine colonoscopy per member per calendar year | | |

Physician office services

| | | |
|------------------------------------|----------------------|----------------------|
| Office visits | 80% after deductible | 60% after deductible |
| Outpatient and home medical visits | 80% after deductible | 60% after deductible |
| Office consultations | 80% after deductible | 60% after deductible |

Emergency medical care

| | | |
|--|----------------------|----------------------|
| Hospital emergency room | 80% after deductible | 80% after deductible |
| Ambulance services – must be medically necessary | 80% after deductible | 80% after deductible |

Diagnostic services

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

Maternity services provided by a physician

| | | |
|-----------------------------|---|----------------------|
| Prenatal and postnatal care | 80% after deductible | 60% after deductible |
| | Includes covered services provided by a certified nurse midwife | |
| Delivery and nursery care | 80% after deductible | 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 | 80% after deductible | 60% after deductible |
| | Unlimited days | |
| Inpatient consultations | 80% after deductible | 60% after deductible |
| Chemotherapy | 80% after deductible | 60% after deductible |

Alternatives to hospital care

| | | |
|---|--|----------------------|
| Skilled nursing care | Not covered | Not covered |
| Hospice care – must be provided through a participating hospice program | 80% after deductible | 80% after deductible |
| | 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 – must be medically necessary and provided by a participating home health care agency | 80% after deductible | 80% after deductible |
| Home infusion therapy – must be medically necessary and given by participating providers | 80% after deductible | 80% after deductible |

Surgical services

| | | |
|---|---|----------------------|
| Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility | 80% after deductible | 60% after deductible |
| Voluntary sterilization | 80% after deductible | 60% after deductible |
| Presurgical consultations | 100% (no deductible or copay) when obtained from a network provider ... | 60% after deductible |

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 (1-800-242-3504) | 80% after deductible | 80% after deductible in designated facilities only |
| Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 80% after deductible | 60% after deductible |
| Kidney, cornea and skin transplants | 80% after deductible | 60% after deductible |
| Specified oncology clinical trials | 80% after deductible | 60% after deductible |

Mental health care and substance abuse treatment

| | | |
|---|----------------------|----------------------|
| Inpatient mental health care | 50% after deductible | 50% after deductible |
| Inpatient substance abuse care | 50% after deductible | 50% after deductible |
| Up to \$15,000 annual maximum | | |
| Outpatient mental health care | 50% after deductible | 50% after deductible |
| Outpatient substance abuse care – in approved facilities only | 50% after deductible | 50% after deductible |
| Up to the state-dollar amount which is adjusted annually | | |

Other covered services

| | | |
|---|---|----------------------|
| Allergy testing and therapy | 80% after deductible | 60% after deductible |
| Chiropractic spinal manipulation | 80% after deductible | 60% after deductible |
| Up to 38 medically necessary visits per calendar year | | |
| Durable medical equipment | 80% after deductible | 80% after deductible |
| Outpatient Diabetes Management Program | 80% after deductible for diabetic medical supplies; 100% (no deductible or copay/coinsurance) for diabetic self-management training | 60% after deductible |
| Outpatient physical, speech and occupational therapy | 80% after deductible | 60% after deductible |
| Unlimited treatment | | |
| Prosthetic and orthotic appliances | 80% after deductible | 80% after deductible |
| Private duty nursing | 50% after deductible | 50% after deductible |
| Prescription drugs | Not covered | Not covered |

*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.

NOTE: A 365-day waiting period is applied to members age 19 and older for pre-existing medical conditions, removal of tonsils and/or adenoids, and voluntary sterilization.

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield certificate and riders. Payment amounts are based on the Blue Cross Blue Shield 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.