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Community BlueSM PPO Plan 4 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 and dollar maximums)

Deductibles	\$500 for one member, \$1,000 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.	\$1,000 for one member, \$2,000 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.
Fixed dollar copays	<ul style="list-style-type: none"> \$10 copay for office visits \$50 copay for emergency room visits 	\$50 copay for emergency room visits
Percent coinsurances Note: Coinsurances apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for mental health care, substance abuse treatment and private duty nursing 20% of approved amount for most other covered services (coinsurance is waived if service is performed in a PPO physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for mental health care, substance abuse treatment and private duty nursing 40% of approved amount for most other covered services
Annual coinsurance dollar maximums – applies to coinsurances for all covered services, except fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent coinsurances.	\$1,500 for one member, \$3,000 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.
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/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <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/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

In-Network

Out-of-Network*

Preventive care services (continued)

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
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 percent copay. One per member per calendar year	60% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay/coinsurance) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay. One routine colonoscopy per member per calendar year	60% after out-of-network deductible

Physician office services

Office visits	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary

Emergency medical care

Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 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

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
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

Prenatal and postnatal care	100% (no deductible or copay/coinsurance) Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible Unlimited days	60% after out-of-network deductible
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

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care – must be provided through a participating hospice program	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).	100% (no deductible or copay/coinsurance)
Home health care – must be medically necessary and provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

In-Network**Out-of-Network*****Surgical services**

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	80% after in-network deductible	60% after out-of-network 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)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities only
Bone marrow transplants – when 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
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care and substance abuse care	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days, up to \$15,000 annual maximum per member	
Outpatient mental health care • Facility and clinic • Physician's office	50% after in-network deductible	50% after in-network deductible
	50% (no deductible)	50% after out-of-network deductible
	Up to \$2,000 annual maximum, combined with inpatient maximum	
Outpatient substance abuse care – in approved facilities only	50% after in-network deductible	50% after in-network deductible
	Up to the state-dollar amount which is adjusted annually	

Other covered services

Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Outpatient Diabetes Management Program	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy	80% after in-network deductible	60% after out-of-network deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

Prescription Drug Coverage (optional)

Blue Preferred [®] Rx prescription drug plan • FDA-approved drugs • State-controlled drugs • Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs (needles and syringes have no coinsurance) (Excludes elective drugs)	20% coinsurance with \$20 minimum payment for each covered prescription drug, up to a 30-day supply.	BCBSM will reimburse you 75% of the approved amount less your coinsurance for each covered prescription drug filled at a non-network pharmacy.
Mail order prescription drug program	\$20 copay per prescription or refill, up to a 90-day supply	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. 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.