



## Community Blue<sup>SM</sup> PPO – Plan 2

### Benefits-at-a-Glance

### Lake Shore Public Schools 67736-661

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 deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
<b>Member's responsibility (deductibles, copays and dollar maximums)</b>		
<b>Deductibles</b>	\$100 for one member, \$200 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Deductible may be waived if service is performed in a PPO physician's office.	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Copays</b>		
<ul style="list-style-type: none"> <li>Fixed dollar copays</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay for office visits</li> <li>\$50 copay for emergency room visits</li> </ul>	\$50 copay for emergency room visits
<ul style="list-style-type: none"> <li>Percent copays <b>Note:</b> Copays apply once the deductible has been met.</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>10% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>30% of approved amount for most other covered services</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
<b>Copay dollar maximums</b> – applies to copays for all covered services – including mental health and substance abuse services – but <b>does not</b> apply to fixed dollar copays and private duty nursing percent copays <b>Note:</b> For groups with 50 or fewer employees or groups that are <b>not</b> subject to the MHP law, mental health care and substance abuse treatment copays <b>do not</b> contribute to the copay dollar maximum.	\$500 for one member, \$1,000 for two or more members each calendar year	\$1,500 for one member, \$3,000 for two or more members each calendar year <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Dollar maximums</b>	\$1 million lifetime maximum per covered specified human organ transplant type and a <b>separate</b> \$5 million lifetime maximum per member for all other covered services and as noted for individual services	

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\* 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"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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 – 90% after deductible	Covered – 70% after deductible
	One per member per calendar year	

**Physician office services**

Office visits	Covered – \$20 copay per office visit	Covered – 70% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 90% after deductible	Covered – 70% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay per office visit	Covered – 70% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay per office visit	Covered – 70% after deductible, must be medically necessary

**Emergency medical care**

Hospital emergency room	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 90% after deductible	Covered – 90% after deductible

**Diagnostic services**

Laboratory and pathology services	Covered – 90% after deductible	Covered – 70% after deductible
Diagnostic tests and x-rays	Covered – 90% after deductible	Covered – 70% after deductible
Therapeutic radiology	Covered – 90% after deductible	Covered – 70% after deductible

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**In-network**

**Out-of-network \***

**Maternity services provided by a physician**

Prenatal and postnatal care	Covered – 100%	Covered – 70% after deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	Covered – 90% after deductible	Covered – 70% 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 <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient consultations	Covered – 90% after deductible	Covered – 70% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 70% 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%
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a <b>participating</b> hospice program <b>only</b> ; 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 <b>participating</b> ambulatory surgery facility	Covered – 90% after deductible	Covered – 70% after deductible
Presurgical consultations	Covered – 100%	Covered – 70% after deductible
Colonoscopy	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary sterilization	Covered – 90% after deductible	Covered – 70% 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 <b>only</b>
	Limited to \$1 million <b>lifetime</b> 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 – 90% after deductible	Covered – 70% after deductible
Specified oncology clinical trials	Covered – 90% after deductible	Covered – 70% after deductible
Kidney, cornea and skin transplants	Covered – 90% after deductible	Covered – 70% after deductible

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**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 and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See "Copay dollar maximums" section for this amount. If you receive your health care benefits through a collectively bargain agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 90% after deductible	Covered – 90% after deductible
	Covered – 90% after deductible	Covered – 70% after deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	Covered – 90% after deductible	Covered – 90% after deductible

**Note:** If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are **not** limited to a copay dollar maximum.

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 • Physician's office	Covered – 50% after deductible	Covered – 50% after deductible
	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	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 – 70% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 70% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – \$20 copay per office visit	Covered – 70% after deductible
	Up to a <b>combined</b> maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to a <b>combined</b> 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

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### Additional riders

<b>Rider CB-RM 100</b> , routine mammograms	Removes deductible and copay requirements from screening mammography services provided by PPO network providers.
<b>Rider CI</b> , contraceptive injections <b>Rider PCD</b> , prescription contraceptive devices <b>Rider PD-CM</b> , prescription contraceptive medications	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p><b>Note:</b> 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.</p>

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Community Blue Plan 2, AUG 2010