



## Community Blue<sup>SM</sup> PPO – Plan 1 Medical Coverage Benefits-at-a-Glance for Lake Orion Community Schools

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. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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 any other plan documents your group uses, 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>	\$750 for one member, \$1,500 for the family (when two or more members are covered under your contract) each calendar year	\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year
<b>Fixed dollar copays</b>	<ul style="list-style-type: none"> <li>\$30 copay for office visits</li> <li>\$150 copay for emergency room visits</li> </ul>	\$150 copay for emergency room visits
<b>Percent copays</b> <b>Note:</b> Copays apply once the deductible has been met.	50% of approved amount for private duty nursing  See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>50% 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 copays.
<b>Annual 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.	Not applicable	\$5,000 for one member, \$10,000 for two or more members each calendar year
<b>Lifetime dollar maximum</b>	None	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

\* 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**

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"> <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
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
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) <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	50% after out-of-network deductible <b>Note:</b> 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% (no deductible or copay) for the first billed colonoscopy <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	50% after out-of-network deductible
	One per member per calendar year	

**Physician office services**

Office visits	\$30 copay per office visit	50% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	100% after in-network deductible	50% after out-of-network deductible, must be medically necessary
Office consultations	\$30 copay per office visit	50% after out-of-network deductible, must be medically necessary
Urgent care visits	\$30 copay per office visit	50% after out-of-network deductible, must be medically necessary

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**In-network**

**Out-of-network \***

**Emergency medical care**

Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible

**Diagnostic services**

Laboratory and pathology services	100% after in-network deductible	50% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	50% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	50% after out-of-network deductible

**Maternity services provided by a physician**

Prenatal and postnatal care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	50% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible Includes covered services provided by a certified nurse midwife	50% after out-of-network deductible

**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.	100% after in-network deductible	50% after out-of-network deductible
Unlimited days		
Inpatient consultations	100% after in-network deductible	50% after out-of-network deductible
Chemotherapy	100% after in-network deductible	50% after out-of-network deductible

**Alternatives to hospital care**

Skilled nursing care – must be in a <b>participating</b> skilled nursing facility	100% after in-network deductible	100% after in-network deductible
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay) 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 (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay)
Home health care – must be medically necessary and provided by a <b>participating</b> home health care agency	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by <b>participating</b> home infusion therapy providers	100% after in-network deductible	100% after in-network deductible

**Surgical services**

Surgery – includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	100% after in-network deductible	50% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	50% after out-of-network deductible
Voluntary sterilization	100% after in-network deductible	50% after out-of-network deductible

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**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)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities <b>only</b>
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	50% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	50% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	50% after out-of-network deductible

**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 “Annual copay dollar maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	100% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	100% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities <b>only</b>
	100% after in-network deductible **	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	100% after in-network deductible **	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

\*\* Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician’s office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

**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 copay amounts. Mental health and substance abuse copays are **not** limited to a copay dollar maximum.

Inpatient mental health care	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	50% after in-network deductible	50% after in-network deductible in participating facilities <b>only</b>
	50% (no deductible)	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	50% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

\* 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 \***

**Other covered services**

Outpatient Diabetes Management Program (ODMP) <b>Note:</b> Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	50% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	50% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$30 copay per office visit Limited to a <b>combined</b> maximum of 24 visits per member per calendar year	50% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible Limited to a <b>combined</b> maximum of 60 visits per member per calendar year	50% after out-of-network deductible <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	See prescription charts	See prescription chart

**Additional riders**

<b>Rider CBD \$750-P</b> , deductible requirement for in-network services	Adds an <b>in-network</b> deductible of \$720 for one member, \$1,500 for the family (when two or more members are covered under your contract) each calendar year for most covered services provided by PPO providers.  Amounts applied toward an annual deductible for out-of-network services also count toward the deductible for in-network services. However, deductible amounts for in-network services are not applied toward the deductible for out-of-network services.
<b>Rider CBD \$2000-NP</b> , deductible requirement for out-of-network services	Increases out-of-network deductible to \$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract).
<b>Rider CB-ET \$150</b> , emergency treatment copay requirement	Increases copay for outpatient hospital emergency room services to \$150.
<b>Rider CB-OV\$30</b> , office visit copay requirement	Increases copay for select office visits to PPO network providers to \$30.
<b>Rider CB-CM-NP \$5000</b> , copay maximum for out-of-network services	Increases out-of-network copay maximum to \$5,000 for one member, \$10,000 for two or more members.
<b>Rider CBC 50% NP</b> , copay requirement for out-of-network services	Increases <b>out-of-network</b> copay to 50% for all covered services. The out-of-pocket copay maximum remains the same unless a CB-CM-NP rider is included.
<b>Rider CI</b> , contraceptive injections <b>Rider PCD</b> , prescription contraceptive devices <b>Rider PD-CM</b> , prescription contraceptive medications	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). <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.
<b>Rider HC-A</b> , hearing care	Provides coverage for hearing aids, including binaural hearing aids, and certain other hearing care services every 36 months.

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