



Otterbase Inc. #41689/000/001 Effective 01/01/10 Community BlueSM PPO Plan / Benefits-at-a-Glance

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates 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 your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

In-network

Out-of-network

Member's responsibility (deductibles, 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 the BCBSM approved amount and the provider's charge.

	In-network	Out-of-network
Deductibles	\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible waived if service is performed in a PPO physician's office.	\$2,000 for one member, \$4,000 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.
Copays		
<ul style="list-style-type: none"> Fixed dollar copays 	<ul style="list-style-type: none"> \$30 copay for office visits \$150 copay for emergency room visits 	\$150 copay for emergency room visits
<ul style="list-style-type: none"> Percent copays 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums		
<ul style="list-style-type: none"> Percent copay maximums – includes general medical only – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing percent copays 	\$3,000 for one member, \$6,000 for two or more members each calendar year	\$6,000 for one member, \$12,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
<ul style="list-style-type: none"> For groups of 51 or more employees (including seasonal and part-time) that are subject to the MHP law, copays for mental health care and substance abuse treatment are subject to a separate copay maximum Note: Groups with 50 or fewer employees or groups that are not subject to the MHP law do not have a copay dollar maximum. 	\$3,000 for one member, \$6,000 for two or more members each calendar year	\$6,000 for one member, \$12,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted for individual services	

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In-network

Out-of-network

Preventive care services – *Payment for preventive services is limited to a combined maximum of \$1,000 per calendar year per member

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"> • 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
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 – 100%	Covered – 60% after deductible
One per calendar year, no age restrictions		

Physician office services

Office visits	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – \$30 copay per office visit	Covered – 60% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$150 copay per visit (copay waived if admitted or for an accidental injury)	Covered – \$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be 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	

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In-network

Out-of-network

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

Alternatives to hospital care

Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year per member	
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 participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered – 80% after deductible	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 transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after deductible



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 care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See “Copay dollar maximums” section for these amounts. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.

Inpatient mental health care	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic • Physician’s office	Covered – 80% after deductible	Covered – 60% after deductible
	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 80% after deductible	Covered – 60% after deductible

Other covered 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 manipulation treatment and osteopathic manipulation treatment	Covered – \$30 copay per office visit	Covered – 60% after deductible
	Up to a maximum of 12 visits per calendar year per member	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a combined maximum of 60 visits per calendar year per member	
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

Additional riders

Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.
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