



## Community Blue<sup>SM</sup> PPO – Plan 2 Benefits-at-a-Glance

This is intended as an easy-to-read summary. 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

#### Deductibles, copays and dollar maximums

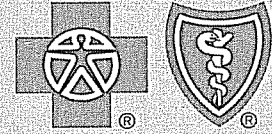
**Note:** Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

<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: Deductible waived if service is performed in a PPO physician's office.</b>	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year <b>Note: Out-of-network deductible amounts also apply toward the in-network deductible.</b>
<b>Copays</b> • Fixed dollar copays  • Percent copays	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
	10% for general services, <b>copay waived if service is performed in a PPO physician's office</b> , and 50% for mental health care, substance abuse treatment and private duty nursing	30% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
<b>Copay dollar maximums</b> • Fixed dollar copays • Percent copays – <b>excludes</b> mental health care, substance abuse treatment and private duty nursing copays	None	None
	\$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: Out-of-network copays also apply toward the in-network maximum.</b>
<b>Dollar maximums</b>	\$1 million lifetime per covered specified human organ transplant type and a <b>separate</b> \$5 million lifetime per member for all other covered services and as noted for individual services	

**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%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	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

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



**In-network**

**Out-of-network**

**Mammography**

Mammography screening	Covered – 90% after deductible	Covered – 70% after deductible
One per calendar year, no age restrictions		

**Physician office services**

Office visits	Covered – \$10 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 – \$10 copay per office visit	Covered – 70% after deductible, must be medically necessary
Urgent care visits	Covered – \$10 copay per office visit	Covered – 70% after deductible, must be medically necessary

**Emergency medical care**

Hospital emergency room	Covered – \$50 copay per visit, waived if admitted or for an accidental injury	Covered – \$50 copay per visit, 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

**Maternity services provided by a physician**

Prenatal and postnatal care	Covered – 100%	Covered – 70% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 90% after deductible	Covered – 70% after deductible
	Includes delivery provided by a certified nurse midwife	

**Hospital care**

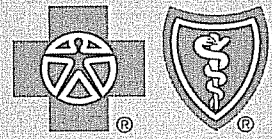
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient consultations	Covered – 90% 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%
	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



**In-network**

**Out-of-network**

**Human organ transplants**

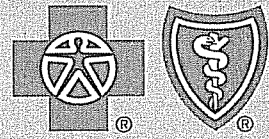
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities <b>only</b>
	Limited to \$1 million <b>lifetime</b> maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (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

**Mental health care and substance abuse treatment**

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	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	

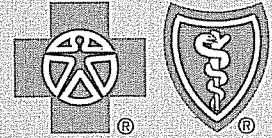
**Other covered services**

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 – \$10 copay per office visit	Covered – 70% after deductible
	Up to a 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
Prescription drugs	Not covered	Not covered



**Additional riders included**

<p><b>Rider CB-PCM-500</b>, preventive care maximum</p>	<p>Increases combined annual maximum for covered preventive care services to \$500. All age and frequency limitations remain the same.</p>
<p><b>Rider CI</b>, contraceptive injections  <b>Rider PCD</b>, prescription contraceptive devices  <b>Rider PD-CM</b>, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications.</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>
<p><b>Rider XVA-2</b>, excludes voluntary abortions</p>	<p>Excludes benefits for voluntary abortions.</p>



## Blue Preferred<sup>®</sup> Rx Prescription Drug Coverage with \$10 Generic / \$20 Brand Name Fixed Dollar Copay Benefits-at-a-Glance

This is intended as an easy-to-read summary. **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.

**Note:** Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, an independent company. Specialty prescription drugs (such as Enbrel<sup>®</sup> and Humira<sup>®</sup>) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at [bcbsm.com](http://bcbsm.com). Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

	Network pharmacy	Non-network pharmacy
<b>Copays</b>		
Generic prescription drugs	\$10 for each drug	\$10 for each drug <b>plus</b> 25% of the BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM	\$10 for each drug	\$10 for each drug <b>plus</b> 25% of the BCBSM approved amount for the drug
Brand name prescription drugs	\$20 for each drug	\$20 for each drug <b>plus</b> 25% of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<b>Copay for up to a 34 day supply:</b> <ul style="list-style-type: none"> <li>• \$10 for each generic drug</li> <li>• \$20 for each brand name drug</li> </ul> <b>Copay for a 35 to 90 day supply:</b> <ul style="list-style-type: none"> <li>• \$20 for each generic drug</li> <li>• \$40 for each brand name drug</li> </ul>	No coverage

**Note:** If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber did not write "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic plus the applicable copay.

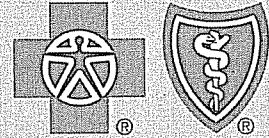
### Covered services

"Rx only" drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <b>Note:</b> Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered – 100% less plan copay	No coverage

**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

**Note:** A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

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



### Features of your plan

<b>Drug interchange and generic copay waiver</b>	Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at <a href="http://bcbsm.com">bcbsm.com</a> . If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
<b>Quantity limits</b>	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at <a href="http://bcbsm.com">bcbsm.com</a> .

### Additional riders included

<b>Rider CI, contraceptive injections</b> <b>Rider PCD, prescription contraceptive devices</b> <b>Rider PD-CM, prescription contraceptive medications</b>	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications. <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.
---	--