

Community BlueSM PPO – Plan 15/0% Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after September 23, 2010 or January 1, 2011

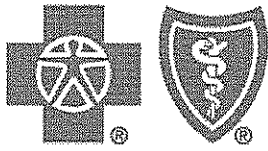
The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this 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. 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 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 *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$2,500 for one member, \$5,000 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.	\$5,000 for one member, \$10,000 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"> • \$5 copay for office visits • \$25 copay for emergency room visits 	\$25 copay for emergency room visits
Percent copays Note: 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"> • 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.	Not applicable	\$5,000 for one member, \$10,000 for two or more members each calendar year
Lifetime dollar maximum	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 *

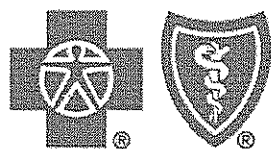
Preventive care services

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"> • 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)	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) 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	80% 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) 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	80% after out-of-network deductible

Physician office services

Office visits	\$5 copay per office visit	80% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	100% after in-network deductible	80% after out-of-network deductible, must be medically necessary
Office consultations	\$5 copay per office visit	80% after out-of-network deductible, must be medically necessary
Urgent care visits	\$5 copay per office visit	80% after out-of-network deductible, must be medically necessary

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In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$25 copay per visit (copay waived if admitted or for an accidental injury)	\$25 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	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% 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	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible Includes covered services provided by a certified nurse midwife	80% after out-of-network deductible

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

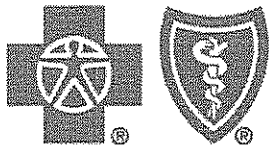
Alternatives to hospital care

Skilled nursing care – must be in a participating 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 – must be provided through a participating hospice program	100% (no deductible or copay)	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 participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care – must be medically necessary and provided by a participating home health care agency	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating 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 participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	80% after out-of-network deductible
Voluntary sterilization	100% after in-network deductible	80% 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 only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% 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.

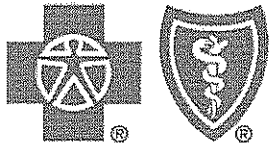
Inpatient mental health care	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities only
• Physician's office	100% after in-network deductible **	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	100% after in-network deductible **	100% after in-network deductible

** 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, up to \$15,000 annual maximum	
Outpatient mental health care		
• Facility and clinic	50% after in-network deductible	50% after in-network deductible, in participating facilities only
• Physician's office	50% (no deductible)	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	50% after in-network deductible	50% after in-network deductible
	Up to the state-dollar amount that is adjusted annually	

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Other covered services

Outpatient Diabetes Management Program (ODMP)	100% (no deductible or copay)	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$5 copay per office visit Limited to a combined maximum of 24 visits per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible Limited to a combined maximum of 60 visits per member per calendar year	80% after out-of-network deductible Note: 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	Not covered	Not covered

Optional riders

Rider CBD \$3000-P , deductible requirement for in-network services	Adds an annual in-network deductible of \$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) for most covered network services. Note: When this rider is selected, Rider CBD \$2500-P must be removed from the package.
Rider CBD \$6000-NP , deductible requirement for out-of-network services	Increases annual out-of-network deductible to \$6,000 for one member, \$12,000 for the family (when two or more members are covered under your contract). Note: When this rider is selected, Rider CBD \$5000-NP must be removed from the package.
Rider CBD \$4000-P , deductible requirement for in-network services	Adds an annual in-network deductible of \$4,000 for one member, \$8,000 for the family (when two or more members are covered under your contract) for most covered network services. Note: When this rider is selected, Rider CBD \$2500-P must be removed from the package.
Rider CBD \$8000-NP , deductible requirement for out-of-network services	Increases annual out-of-network deductible to \$8,000 for one member, \$16,000 for the family (when two or more members are covered under your contract). Note: When this rider is selected, Rider CBD \$5000-NP must be removed from the package.

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