Community Blue[SM] PPO – Plan 1
Benefits-at-a-Glance for Flat Rock Community Schools #49436-000,001,002,003,004,005,006

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 our approved amount and the provider's charge.		
Deductibles	None	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year
Copays • Fixed dollar copays	$10 for office visits and $50 for emergency room visits	$50 for emergency room visits
• Percent copays	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums • Fixed dollar copays	None	None
• Percent copays – **excludes** mental health care, substance abuse treatment and private duty nursing copays	Not applicable	$2,000 for one member, $4,000 for two or more members each calendar year
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	

Preventive care services – *Payment for preventive services is limited to a **combined** maximum of $250 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 • 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

	In-network	Out-of-network
Mammography		
Mammography screening	Covered – 100% One per calendar year, no age restrictions	Covered – 80% after deductible
Physician office services		
Office visits	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – $10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – $10 copay per office visit	Covered – 80% 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 – 100%	Covered – 100%
Diagnostic services		
Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100% Includes care provided by a certified nurse midwife	Covered – 80% after deductible
Delivery and nursery care	Covered – 100% Includes delivery provided by a certified nurse midwife	Covered – 80% after 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.	Covered – 100% Unlimited days	Covered – 80% after deductible
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 100% Up to 120 days per member per calendar year	Covered – 100%
Hospice care	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	Covered – 100%
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% 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 **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 – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100%	Covered – 80% after deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	Covered – 50%	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50%	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient mental health care		
• Facility and clinic	Covered – 50%	Covered – 50%
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 50%	Covered – 50%
	Up to the state-dollar amount that is adjusted annually	
Other covered services		
Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – 100%	Covered – 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%
Prescription drugs	Not covered	Not covered

Additional riders

Rider CI, contraceptive injections **Rider PCD,** prescription contraceptive devices	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs 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 XVA-2, excludes voluntary abortions	Excludes benefits for any services related to an abortion except for a spontaneous abortion, or to prevent the death of the woman upon whom the abortion is performed. BCBSM does pay for services or supplies to treat complications resulting from an abortion.