Community Blue[SM] PPO – Plan 10 Medical Coverage (Modified) Benefits-at-a-Glance

Effective February 1, 2013

Grosse Pointe Public Schools
007007236-0001, 0003

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.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

	In-network	**Out-of-network ***
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$250 for one member $500 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.	$500 for one member $1,000 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	• $20 copay for office visits • $100 copay for emergency room visits	$100 copay for emergency room visits
Percent copays **Note:** Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 10% 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 copays.	• 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 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.	$500 for one member $1,000 for two or more members each calendar year	$4,000 for one member $8,000 for two or more members each calendar year **Note:** Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

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	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
Voluntary sterilizations for females	100% (no deductible or copay)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay) • 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.	60% 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.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	
Physician office services		
Office visits – must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	90% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Urgent care visits – must be medically necessary	$20 copay per office visit	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	90% after in-network deductible

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	In-network	Out-of-network *
Diagnostic services		
Laboratory and pathology services	90% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care visits	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	90% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	90% after in-network deductible	60% after out-of-network deductible
Chemotherapy	90% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	90% after in-network deductible	90% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	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	90% after in-network deductible	90% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	90% after in-network deductible	90% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** See "Preventive care services" section for voluntary sterilizations for females.	90% after in-network deductible	60% after out-of-network deductible
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)	90% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	60% after out-of-network deductible

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	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 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	100% after out-of-network deductible
	Up to 60 days per calendar year	
Inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Up to 60 days per calendar year	
Outpatient mental health care: **up to 50 visits per calendar year, 120 lifetime**		
• 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 **	100% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **Up to 60 days per calendar year**	50% after in-network deductible **	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

** 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.

Autism spectrum disorders, diagnoses and treatment

Note: If your group is self-funded, check with your group or check your plan documents to see if the following autism benefits are available to you.

Applied behavioral analyses (ABA) treatment – limited to an annual maximum of $50,000 per member, through age 18 (limits may be waived on an individual consideration basis)	Not Covered	Not Covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder – through age 18	Not Covered	Not Covered
Other covered services, including mental health services, for Autism Spectrum Disorder	Not Covered	Not Covered

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	In-network	Out-of-network *
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. **Note:** Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation	$20 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	90% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
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.	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.

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